United States Virgin Island

Eligible Provider EHR Incentive Program Application Manual

Date of Publication: 02.03.2015

Document Version: 1.1

Privacy Rules

The Health Insurance Portability and Accountability Act of 1996 (HIPAA – Public Law 104-191) and the HIPAA Privacy Final Rule[1] and the American Recovery and Reinvestment Act (ARRA) of 2009 provides protection for personal health information.

Protected health information (PHI) includes any health information and confidential information, whether verbal, written, or electronic, created, received, or maintained by Molina Healthcare. It is health care data plus identifying information that would allow the data to tie the medical information to a particular person. PHI relates to the past, present, and future physical or mental health of any individual or recipient; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. Claims data, prior authorization information, and attachments such as medical records and consent forms are all PHI.

[1] 45 CFR Parts 160 and 164, Standards for Privacy of Individually Identifiable Health Information; Final Rule

Revision History

Version	Date	Author	Action/Summary of Changes	Status
1.0	12.31.14	Karla Battle	Modified to apply the Stage 1 2013 and 2014 rules	

Table of Contents

1. Introduction 12
1.1 Eligible Professionals (EP) 12
1.2 Registering with CMS 14
2. Information Needed 15
2.1 Eligible Provider Attestation Workbook - Overview 15
2.2 Eligible Provider Attestation Workbook – Provider Information 17
2.3 Eligible Provider Attestation Workbook – Medicaid Volume Information and Questions 19
2.4 Eligible Provider Attestation Workbook – EHR Certification Information 21
2.5 Eligible Provider Attestation Workbook – Out-of-State Volume Entries 23
2.6 Eligible Provider Attestation Workbook – Meaningful Use Measures 23
3. Required Supporting Documentation 24
4. Obtaining an United States Virgin Islands (USVI) Medicaid Management Information System (VIMMIS) Login 25
5. Enrolling in USVI Medicaid 26
6. Determine If Intend to Use Group/Clinic Medicaid Volume to meet Medicaid Volume Requirements 27
7. Finding EHR Certification Number 28
8. System Requirements 29
9. Navigation 30
9.1 Breadcrumbs 30
9.2 Use of the Navigation Features 30
9.2.1 Help Hyperlink 30
9.2.2 USVI Medicaid EHR Incentive Program Account Hyperlink 31
9.2.3 Back to VI MMIS Portal 31
9.2.4 Home Tab 31
9.2.5 Registration Tab 32
9.2.6 Attestation Tab 33
9.2.7 The Standard Buttons 35
10. Using the USVI Medicaid EHR Incentive Program Application 36
10.1 Pre-eligibility check on receipt of CMS registration ID 38
10.2 Login to the USVI Medicaid EHR Incentive Solution 39
10.2.1 Starting USVI Medicaid EHR Incentive Program application 39
10.3 Registering a Provider within USVI Medicaid EHR Incentive Program 44
10.3.1 Registration – Add option 46
10.3.2 Registration – Select Option 48
10.3.3 Registration – Remove Option 48
10.4 Attestation 49
10.4.1 Attestation Eligibility 55

10.4.1.1 Encounter Calculation 56
10.4.1.2 Eligibility Screen 1 – Service Setting 56
10.4.1.3 Eligibility Screen 2 – Volume Check 58
10.4.1.3.1 Out of State Encounters 59
10.4.1.3.2 Volume Screen 3 – If initial Eligibility volume is not met 63
10.4.1.3.3 Volume Screen 4 – Needy Patient Volume 65
10.4.2 Attestation Payment 70
10.4.3 Certified EHR Technology 71
11. Meaningful Use Selected 76
11.1 Meaningful Use Core Measures 76
11.1.1 2013 Meaningful Use Core Measures 77
11.1.2 2014 Meaningful Use Core Measures 78
11.1.3 Meaningful Use Core Question General Workflow Functionality 79
11.2 Meaningful Use Menu Measures 79
11.2.1 Meaningful Use Question General Workflow Functionality 81
11.3 Clinical Quality Measures 82
11.3.1 2013 MU Stage 1 Clinical Quality Measure Entry 82
11.3.2 2014 MU Stage 1 Clinical Quality Measure Entry 85
11.3.3 Clinical Quality Measures Meaningful Use Question General Workflow Functionality 89
12. Submit Attestation and payment status 91
12.1 Supporting Documentation 93
13. Status Grid 96
14. Successful Registration with CMS Email 97
15. Submitted Attestation Email 98
16. Error occurred when processing registration Email 99
17. Attestation Accepted Email 100
18. Error Occurred While Processing Registration – Medicaid Enrollment failed Email 101
19. Attestation Error – Practice predominately in a Hospital Setting Email 102
20. Attestation Error – Medicaid Claims count failed Email 103
21. Attestation Paid Email 104
22. Attestation Payment Denied Email 105
23. Attestation Payment Denied – Pay Hold found 106
24. Attestation excluded from Payment Email 107
25. Attestation Rejected Email 108
26. Attestation Pended for Out of State Entries 109
27. Attestation Failed Meaningful Use 110
28. 2013 ONLY Meaningful Use Core Measures Screen Shots 111
29. Meaningful Use Menu Measures Screen Shots 129
30. 2013 ONLY Clinical Quality Measures Screen Shots 140

Table of Figures and Tables

Figure 1 - Eligible Provider Workbook - Worksheet Instructions 16
Figure 2 - Eligible Provider Workbook - Provider Information 18
Figure 3 - Eligible Provider Workbook - Medicaid Volume 20
Figure 4 - Eligible Provider Workbook - EHR Certification Number 22
Figure 5 - Eligible Provider Workbook - Out-of-State 23
Figure 6 - Certified health IT Product List site 28
Figure 7 - Breadcrumbs 30
Figure 8 - Feature Description 30
Figure 9 - Update Account Screen 31
Figure 10 - Home Page 32
Figure 11 – Registration Instructions Page 33
Figure 12 - Attestation Instruction Page 34
Figure 13 - Standard Buttons 35
Figure 14 - Attestation Flowchart 37
Figure 15 - USVI Login Screen 40
Figure 16 - USVI Welcome Screen 41
Figure 17 - Provider Incentive About this Site Page 42
Figure 18 - Home Page 43
Figure 19 - Registration Tab 44
Figure 20 - Registration Tab - Registration Home Page 45
Figure 21 - Registration Tab - No records to display 46
Figure 22 - Registration Tab - Add Registration 46
Figure 23 - Registration Tab - Registration Information Page 47
Figure 24 - Add Registration Error Message 47
Figure 25 - Registration Tab - Registration Information Section 48
Figure 26 - Registration Tab - Remove Option 48
Figure 27 - Attestation Tab 50
Figure 28 - Attestation Tab - Attestation Selection 51
Figure 29 - Attestation Tab - Attestation Topic Listing 52
Figure 30 - Attestation Tab - Verify Registration 54
Figure 31 - Attestation Tab - Service Setting 57
Figure 32 - Attestation Tab - Service Setting Error 57
Figure 33 - Attestation Tab - Medicaid Patient Volume 60
Figure 34 - Attestation Tab - Out-of-State Medicaid Patient Volume 61
Figure 35 – Attetation Tab - Out-of-State Entry - Add/Edit Screen 62
Figure 36 - Attestation Tab - FQHC/RHC Patient Volume 64

Figure 37 - Attestation Tab - Needy Patient Volume at FQHC/RHC 66
Figure 38 - Attestation - Needy Out-of-State Patient Volume Entry/Edit Screen 69
Figure 39 - Pediatrician 20% volume payment calendar 71
Figure 40 - Eligible Providers payment calendar 71
Figure 41 - Certified EHR Technology Page 72
Figure 42 -Certified EHR Questions if EHR not certified 2014 Edition 74
Figure 44 - 2013 Meaningful Use Core Measures List 77
Figure 45 - Meaningful Use Core Measures List 78
Figure 46 - Meaningful Use Menu Measures List 80
Figure 47 - 2013 Clinical Quality Measure Core List 83
Figure 48 - 2013 Clinical Quality Measures if zero in denominator 84
Figure 49 - 2013 Clinical Quality Measures Beginning of 38 CQMs 84
Figure 50 - 2013 Clinical Quality Measures remaining of the 38 CQMs 85
Figure 51 - 2014 Clinical Quality Measures 86
Figure 52 - 2014 Clinical Measures (continued) 87
Figure 53 - 2014 Clinical Measures (continued) 88
Figure 54 - 2014 Clinical Measures 89
Figure 55 - Attestation Tab - Submit Attestation Check Email Address 92
Figure 56 - Submit Attestation - Supporting Documentation - Add Screen 93
Figure 57 - Submit Attesttion - Submission Receipt Page 94
Figure 58 - Attestation Status Grid 96
Figure 59 - Email - Ready to attest 97
Figure 60 - Email - Submitted Attestation 98
Figure 61 - Email - Error Processing Registration 99
Figure 62 - Email - Accepted Attestation 100
Figure 63 - Email - Enrollment Failed 101
Figure 64 - Email – Volume indicates practice in Hospital 102
Figure 65 - Email - Medicaid Claims not found 103
Figure 66 - Email - Cannot validate Medicaid Claims 103
Figure 67 - Email - Attestation Paid 104
Figure 68 - Email - Attestation payment denied 105
Figure 69 - Email - Attestation Payment denied, payhold found 106
Figure 70 - Email - Attestattion payment denied, Duplicate payment found 107
Figure 71 - Email - Attestation rejected 108
Figure 72 - Email - Attestation pended for validation of out-of-state entries 109
Figure 73 - Email - Attestation failed meaningful use 110
Meaningful Use Core Question 1 – CPOE for Medication Orders 111
Meaningful Use Core Question 1 – CPOE for Medication Orders if exclusion does not apply 112
Meaningful Use Core Measure Question 2 – Drug Interaction Checks 113

Meaningful Use Core Question 3 – Maintain Problem List 114
Meaningful Use Core Question 4 – e-Prescribing 115
Meaningful Use Core Question 4 – answered No to exclusions 116
Meaningful Use Core Question 5 – Active Medication List 117
Meaningful Use Core Question 6 – Medication Allergy List 118
Meaningful Use Core Question 7 – Record Demographics 119
Meaningful Use Core Question 8 - Record vitals 120
Meaningful Use Core – Record Vitals exclusion 121
Meaningful Use Core Question 9 – Record Smoking Status and answer No to exclusion 123
Meaningful Use Core Question 10 – Clinical Decision Support Rule 124
Meaningful Use Core Question 11 – Electronic Copy of Health Information and answer No to exclusion 125
Meaningful Use Core Question 12 – Clinical Summaries and answer No to exclusion 127
Meaningful Use Core Question 13 – Protect Electronic Health Information 128
Meaningful Use Menu Measures Question 1 – Immunization Registries Data Submission 129
Meaningful Use Menu Measures Question 1 – Immunization Registries answered No to exclusion 130
Meaningful Use Menu Measures Question 2 – Syndromic Surveillance Data Submission 131
Meaningful Use Menu Measure Question 3 – Drug Formulary Checks and answer No to exclusion 132
Meaningful Use Menu Measure Question 4 – Clinical Lab Test Results and answer No to exclusion 133
Meaningful Use Menu Measures Question 5 – Patient Lists 134
Meaningful Use Menu Measures Question 6 – Patient Reminders and answer No to exclusion 135
Meaningful Use Menu Measures Question 7 – Patient Electronic Access and answer No to exclusion 136
Meaningful Use Menu Measure Question 8 – Patient-specific Education Resources 137
Meaningful Use Menu Measure Question 9 – Medication Reconciliation and answer No to exclusion 138
Meaningful Use Menu Measure Question 10 – Transition of Care Summary and answer No to exclusion 139
Clinical Quality Measures Question 1 – Adult Weight Screening and Follow up 140
Clinical Quality Measure Question 2 – Hypertension: Blood Pressure Measurement 140
Clinical Quality Measure Question 3 – Preventive Care and Screening Measure Pair 141
Clinical Quality Measure Question 1 if denominator is 0- Preventive Care and Screening: Influenza Immunization for Patients > 50 years old 142
Clinical Quality Measure Question 2 if denominator is 0 – Weight Assessment and Counseling for Children and Adolescents 142
Clinical Quality Measure Question 3 if denominator is 0 – Childhood Immunization Status ... 143

Clinical Quality Measure Question 1 – Diabetes: HbA1c Poor Control 144
Clinical Quality Measure Question 2 – Diabetes: LDL Management & Control..... 144
Clinical Quality Measure Question 3 – Diabetes: Blood Pressure Management 145
Clinical Quality Measure Question 4 – HF: ACE Inhibitor or ARB for LVSD..... 145
Clinical Quality Measure Question 5 – CAD: Beta-blocker Therapy for CAD patients with MI 146
Clinical Quality Measure Question 6 – Pneumonia Vaccination Status for Older Adults 146
Clinical Quality Measure Question 7 – Breast Cancer Screening 147
Clinical Quality Measure Question 8 – Colorectal Cancer Screening..... 147
Clinical Quality Measure Question 9 – CAD: Oral Antiplatelet Therapy..... 148
Clinical Quality Measure Question 10 – HF: Beta-blocker Therapy for LVSD 148
Clinical Quality Measure Question 11 – Anti-depressant medication management 149
Clinical Quality Measure Question 12 – POAG: Optic Nerve Evaluation..... 149
Clinical Quality Measure Question 13 – Diabetic Retinopathy: Documentation..... 150
Clinical Quality Measure Question 14 – Diabetic Retinopathy: Communication..... 150
Clinical Quality Measure Question 15 – Asthma Pharmacologic Therapy..... 151
Clinical Quality Measure Question 16 – Asthma Assessment 151
Clinical Quality Measure Question 17 – Appropriate Testing for Children for Pharyngitis..... 152
Clinical Quality Measure Question 18 – Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC..... 152
Clinical Quality Measure Question 19 – Oncology Colon Cancer: Chemotherapy for Stage III153
Clinical Quality Measure Question 20 – Prostate Cancer: Avoidance of Overuse of Bone Scan 153
Clinical Quality Measures Question 21 – Smoking & Tobacco Use Cessation, Medical assistance 154
Clinical Quality Measures Question 22 – Diabetes: Eye Exam 154
Clinical Quality Measure Question 23 – Diabetes: Urine Screening 155
Clinical Quality Measure Question 24 – Diabetes: Foot Exam..... 155
Clinical Quality Measure Question 25 – CAD: Drug Therapy for Lowering LDL-Cholesterol 156
Clinical Quality Measure Question 26 – Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation..... 156
Clinical Quality Measure Question 27 – IVD: Blood Pressure Management 157
Clinical Quality Measure Question 28 – IVD: Use of Aspirin or another Antithrombotic..... 157
Clinical Quality Measure Question 29 – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment 158
Clinical Quality Measure Question 30 – Prenatal Care: Screening for HIV 159
Clinical Quality Measure Question 31 – Prenatal Care: Anti-D Immune Globulin..... 159
Clinical Quality Measure Question 32 – Controlling High Blood Pressure..... 159
Clinical Quality Measure Question 33 – Cervical Cancer Screening..... 160

Clinical Quality Measure Question 34 – Chlamydia Screening for Women 161
Clinical Quality Measure Question 35 – Use of Appropriate Medications for Asthma 162
Clinical Quality Measure Question 36 – Low Back Pain: Use of Imaging Studies 163
Clinical Quality Measure Question 37 – Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control 163
Clinical Quality Measure Question 38 – Diabetes: HbA1c Control < 8% 164

1. Introduction

The Electronic Health Records (EHR) Incentive Payment is a federal program offering financial support to assist eligible providers to adopt, implement, upgrade certified EHR technology, or meaningful use of an EHR system. The federal program defines the options as follows.

- Adopt: to acquire and install a certified EHR technology,
- Implement: to train staff, deploy tools, exchange data,
- Upgrade: to expand functionality or interoperability
- Meaningful Use: to display that the EHR is being used to positively affect the care of the patient.

The program goals are to improve outcomes, facilitate access, simplify care, and reduce costs of healthcare nationwide by:

- Enhancing care coordination and patient safety
- Reducing paperwork and improving efficiencies
- Facilitating information sharing across providers, payers, and state lines
- Enabling communication of health information to authorized users through state Health Information Exchange (HIE) and the National Health Information Network (NHIN).

Incentives will be available through both Medicaid and Medicare. Eligible healthcare professionals will be required to choose between Medicaid and Medicare. The Department of Human Services (DHS) will administer the Medicaid EHR Incentive Payment program for USVI.

1.1 Eligible Professionals (EP)

The Center for Medicare & Medicaid Services (CMS) has defined eligible professionals for the Electronic Health Record Incentive program for Medicaid as follows:

- **An actively enrolled Medicaid Provider with the State Medicaid program with one of the below provider types:**

  - Physicians (primarily doctors of medicine and doctors of osteopathy)
  - Nurse practitioner
  - Certified nurse-midwife
  - Dentist
  - A Physician Assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant where:
    1. PA is the primary provider in a clinic
    2. PA is a clinical or medical director at a clinical site of practice; or
    3. PA is an owner of an RHC.

- **To be eligible for the incentive payment, professional providers meeting the provider type requirement above, must also meet one of the following Medicaid patient volume criteria:**

  - ❑ Have a minimum 30% Medicaid patient volume
  - ❑ Have a minimum 20% Medicaid patient volume, and also be enrolled as a practicing physician with a specialty of pediatrician with USVI Medicaid
  - ❑ Practice predominantly in a Federally Qualified Health Center or Rural Health Center and have a minimum 30% patient volume attributable to needy individuals

- **The provider must also not practice predominately in a hospital setting. Providers who see more than 90% of their Medicaid patients in a hospital inpatient or emergency room setting are considered to be practicing predominately in a hospital setting.**
- **Providers must indicate if they are adopting, upgrading, or implementing a certified EHR solution during their attestation process to proceed with submittal. For Year 1, providers do not have to demonstrate meaningful use.**

The USVI Medicaid EHR Incentive Payment Solution will verify providers meet the above requirements by validating the provider's claims-based data within the MMIS upon receiving the EHR incentive payment solution's registration and attestation from the NLR. In addition to validating the above criteria electronically, the system will perform the following validations:

- ❑ Providers must pass a systematic check of claims volume and place of service relative to the amount of Medicaid patient volume they claim to have seen during the attestation process they complete online. ***Claims for providers for patients within a hospital setting will not be considered for their Medicaid patient volume since providers are supposed to by predominately office based.***
- ❑ Providers will not be paid if currently under review with USVI or not actively enrolled with Medicaid.
- ❑ The provider's Pay To Providers indicated within the NLR registration must also be an active Medicaid provider to receive payment on behalf of the attesting provider.

USVI Eligible Providers attestation timeline is below.

- ❑ EPs will have until 5/2/15 to attest for 2014.
  - ❑ Claims Volume check will be 90 days in 2013.
  - ❑ EHR Certification check will be 90 days in 2014.
- ❑ EPs may choose to wait to attest for 2015
  - ❑ Claims Volume check will be 90 days in 2014.
  - ❑ EHR Certification check will be 90 days in 2015.
- ❑ Regardless of Attestation Year
  - ❑ Must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

1.2 Registering with CMS

Prior to participating in the USVI Medicaid EHR Incentive program, the provider first must register for the **EHR Incentive Program** within the National Level Repository(NLR) system to sign up for the program at the national level and must select **"Medicaid"** as its desired payment path and **"USVI"** as its assigned state for attestation. This will enable the National Level Repository (NLR) solution to notify the USVI Medicaid EHR Incentive Payment solution of the provider's intent to attest for incentive payment. Visit the National Level Repository (NLR) solution at https://ehrincentives.cms.gov/hitech/login.action to register.

Once the provider has successfully registered with the NLR for the USVI Medicaid EHR Incentive Program, the provider must complete the attestation for the year with the **USVI Medicaid EHR Incentive Payment** solution by logging into the secure Medicaid provider online portal https://www.vimmis.com USVI Health PAS Online Provider portal **after waiting at minimum 48 hours** for the Incentive registration to be processed and received by USVI Medicaid EHR Incentive program application from the NLR. Providers who do not have access to the USVI Provider Web portal can request access via an online form at: https://www.vimmis.com.

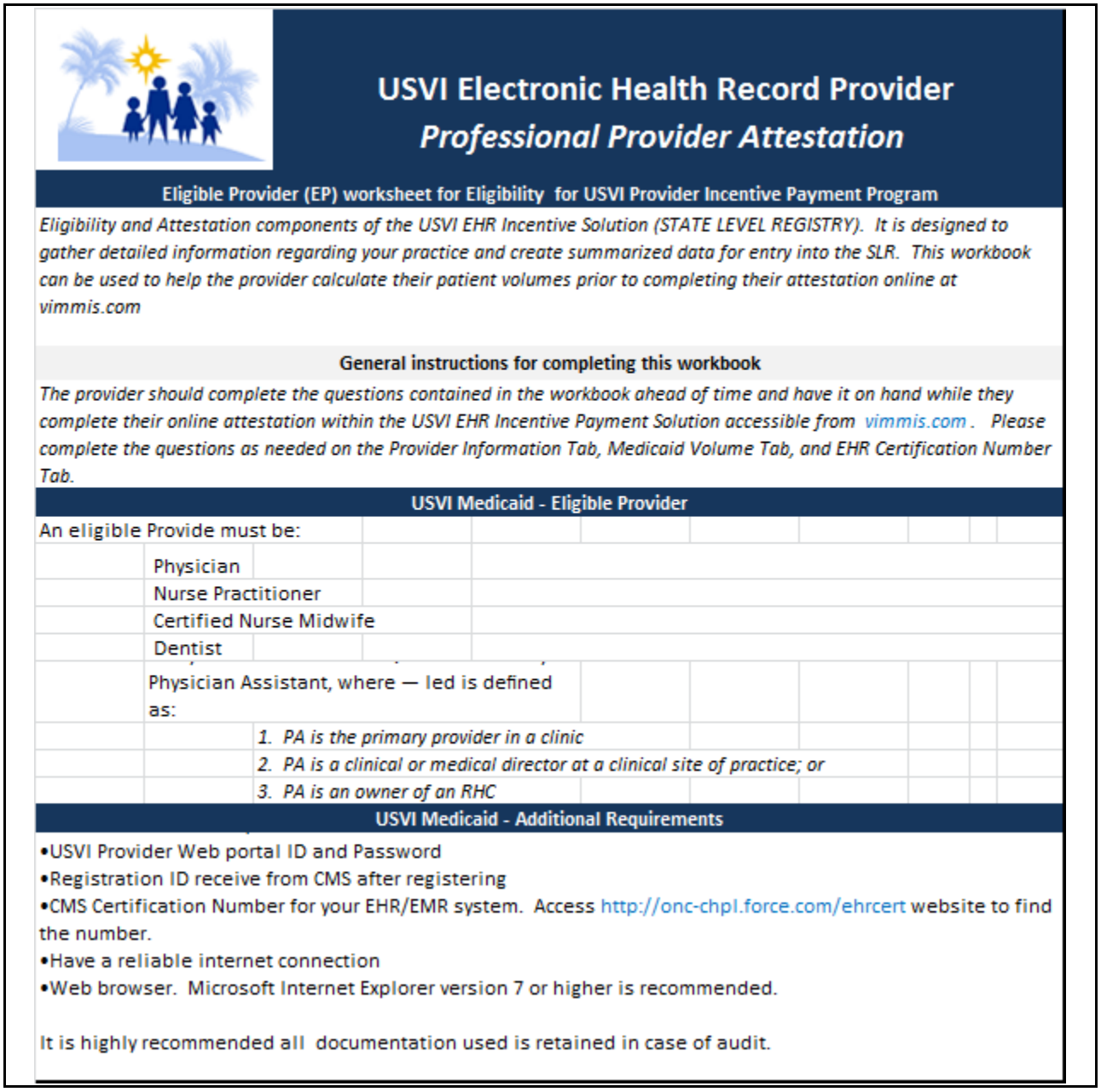
NOTE: If the provider wishes to receive any of the attestation update e-mails from the USVI Medicaid EHR Incentive Program application, the provider must add the email address to the CMS registration information. The USVI Medicaid EHR Incentive Program solution will send emails to this address as the attestation status changes during the attestation process.

2. Information Needed

Before a provider can begin to complete the EHR Incentive Program attestation process, the provider or clinic/practice will need to gather all of the information necessary to complete the attestation correctly. The USVI Medicaid EHR Incentive Payment program has created a workbook to guide the provider or representative user through obtaining the appropriate data needed to complete an attestation successfully. The workbook is available in PDF format. This workbook is embedded within this User Manual in the immediate pages below, as well as available on the vimmis.com portal. The Provider Workbook provides the questions CMS requires and can be used to gather answers before logging into the USVI Medicaid EHR Incentive Payment program online application. The items below are a sample of the topics needed to use the USVI Medicaid EHR Provider Incentive Program application in addition to the workbook.

2.1 Eligible Provider Attestation Workbook - Overview

The first tab of the workbook describes the eligibility requirements for the professional provider and web requirements for utilizing the USVI Medicaid EHR Incentive payment program application.



USVI Electronic Health Record Provider
Professional Provider Attestation

Eligible Provider (EP) worksheet for Eligibility for USVI Provider Incentive Payment Program

Eligibility and Attestation components of the USVI EHR Incentive Solution (STATE LEVEL REGISTRY). It is designed to gather detailed information regarding your practice and create summarized data for entry into the SLR. This workbook can be used to help the provider calculate their patient volumes prior to completing their attestation online at vimmis.com

General instructions for completing this workbook

The provider should complete the questions contained in the workbook ahead of time and have it on hand while they complete their online attestation within the USVI EHR Incentive Payment Solution accessible from vimmis.com. Please complete the questions as needed on the Provider Information Tab, Medicaid Volume Tab, and EHR Certification Number Tab.

USVI Medicaid - Eligible Provider

An eligible Provide must be:

- Physician
- Nurse Practitioner
- Certified Nurse Midwife
- Dentist
- Physician Assistant, where — led is defined as:
  1. *PA is the primary provider in a clinic*
  2. *PA is a clinical or medical director at a clinical site of practice; or*
  3. *PA is an owner of an RHC*

USVI Medicaid - Additional Requirements

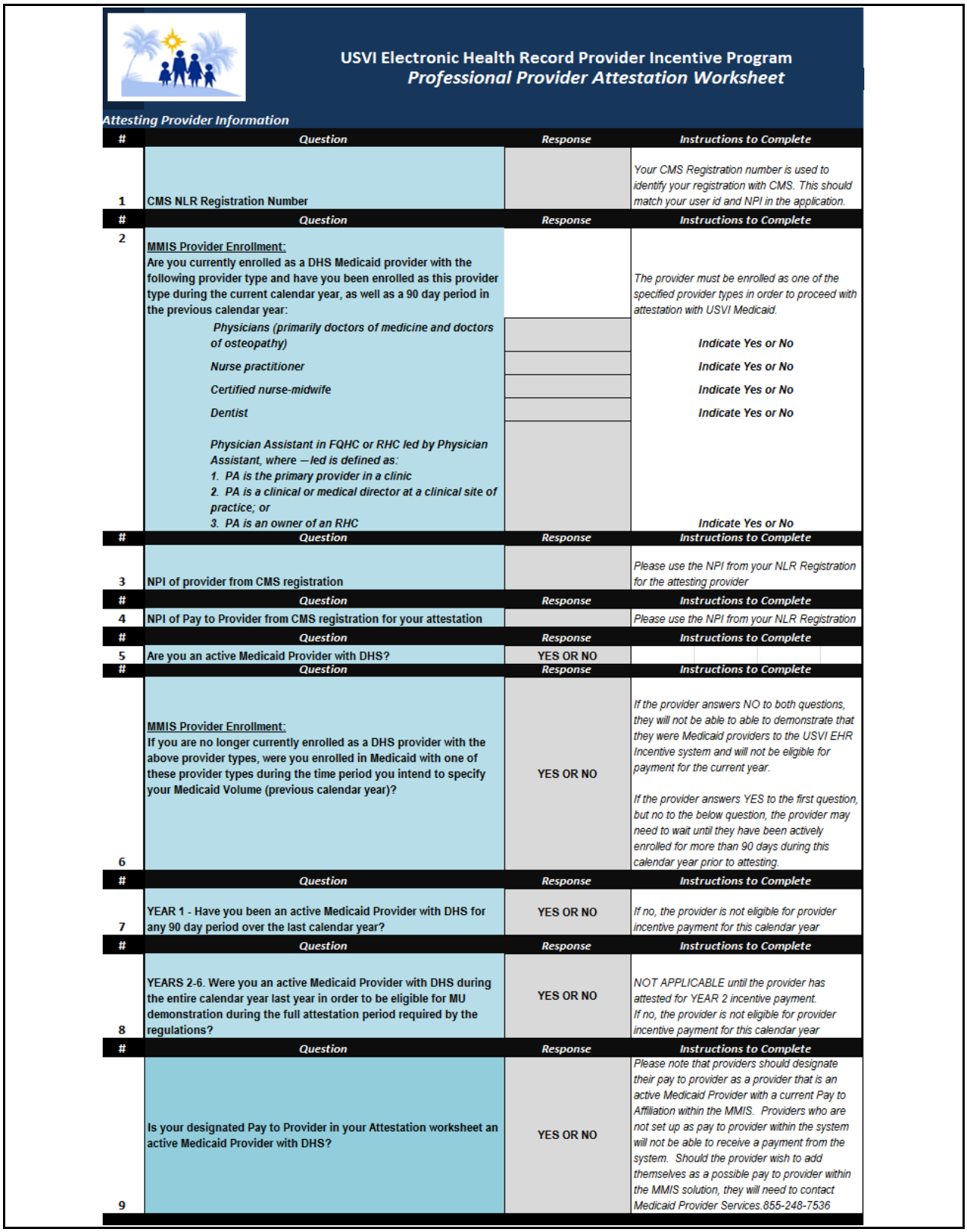
- USVI Provider Web portal ID and Password
- Registration ID receive from CMS after registering
- CMS Certification Number for your EHR/EMR system. Access http://onc-chpl.force.com/ehrcert website to find the number.
- Have a reliable internet connection
- Web browser. Microsoft Internet Explorer version 7 or higher is recommended.

It is highly recommended all documentation used is retained in case of audit.

Figure 1 - Eligible Provider Workbook - Worksheet Instructions

2.2 Eligible Provider Attestation Workbook – Provider Information

The second tab of the workbook requests from the professional provider the identification requirements, provider type/specialty requirements and enrollment requirements for the USVI Medicaid EHR Incentive payment program attestation. There are nine questions in the Provider Information section.



USVI Electronic Health Record Provider Incentive Program
Professional Provider Attestation Worksheet

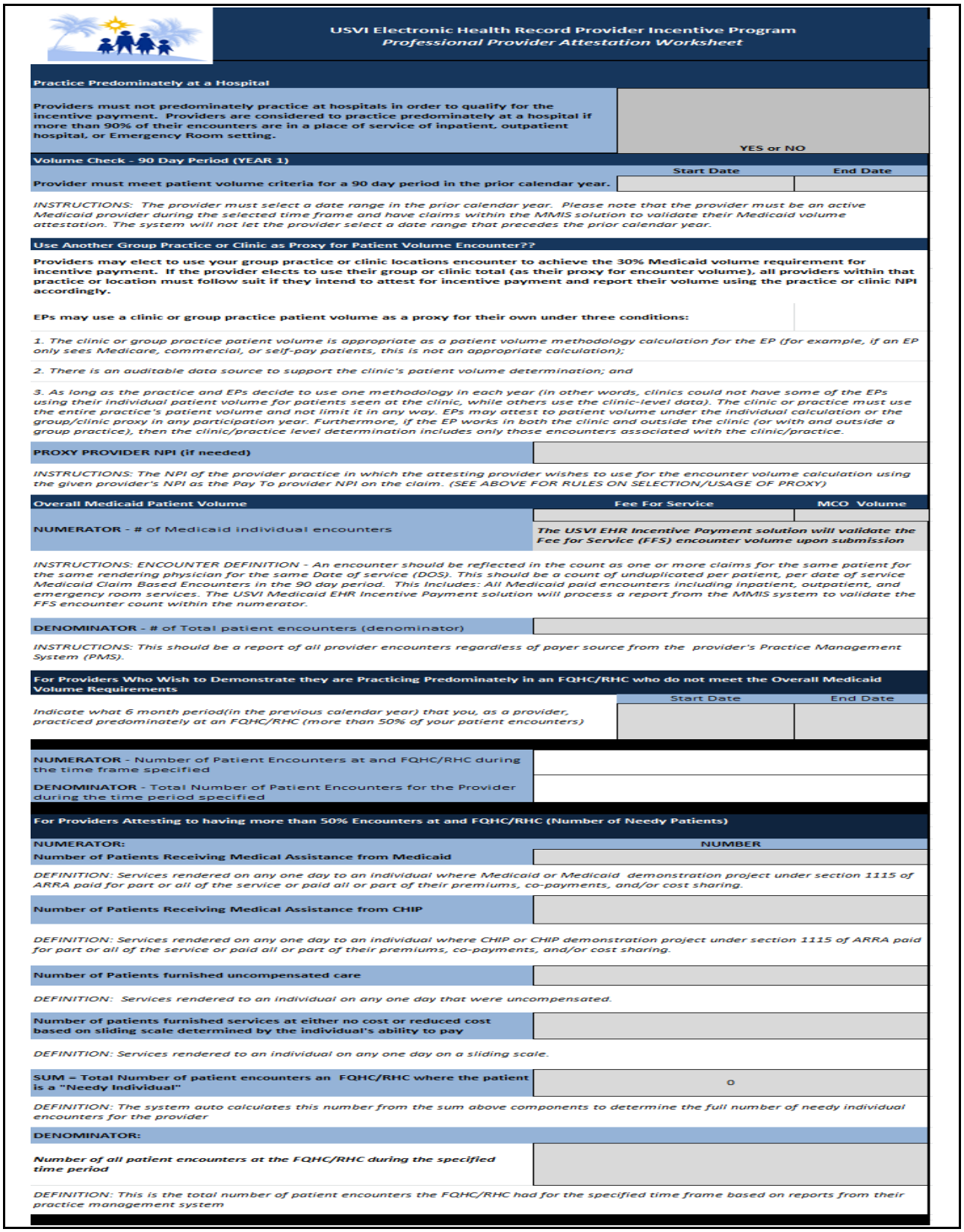
Attesting Provider Information

#	Question	Response	Instructions to Complete
1	CMS NLR Registration Number		*Your CMS Registration number is used to identify your registration with CMS. This should match your user id and NPI in the application.*
#	**Question**	**Response**	**Instructions to Complete**
2	**MMIS Provider Enrollment:** **Are you currently enrolled as a DHS Medicaid provider with the following provider type and have you been enrolled as this provider type during the current calendar year, as well as a 90 day period in the previous calendar year:**		*The provider must be enrolled as one of the specified provider types in order to proceed with attestation with USVI Medicaid.*
	Physicians (primarily doctors of medicine and doctors of osteopathy)		***Indicate Yes or No***
	Nurse practitioner		***Indicate Yes or No***
	Certified nurse-midwife		***Indicate Yes or No***
	Dentist		***Indicate Yes or No***
	Physician Assistant in FQHC or RHC led by Physician Assistant, where –led is defined as: *1. PA is the primary provider in a clinic* *2. PA is a clinical or medical director at a clinical site of practice; or* *3. PA is an owner of an RHC*		***Indicate Yes or No***
#	**Question**	**Response**	**Instructions to Complete**
3	NPI of provider from CMS registration		*Please use the NPI from your NLR Registration for the attesting provider*
#	**Question**	**Response**	**Instructions to Complete**
4	NPI of Pay to Provider from CMS registration for your attestation		*Please use the NPI from your NLR Registration*
#	**Question**	**Response**	**Instructions to Complete**
5	Are you an active Medicaid Provider with DHS?	YES OR NO	
#	**Question**	**Response**	**Instructions to Complete**
6	**MMIS Provider Enrollment:** **If you are no longer currently enrolled as a DHS provider with the above provider types, were you enrolled in Medicaid with one of these provider types during the time period you intend to specify your Medicaid Volume (previous calendar year)?**	YES OR NO	*If the provider answers NO to both questions, they will not be able to able to demonstrate that they were Medicaid providers to the USVI EHR Incentive system and will not be eligible for payment for the current year.* *If the provider answers YES to the first question, but no to the below question, the provider may need to wait until they have been actively enrolled for more than 90 days during this calendar year prior to attesting.*
#	**Question**	**Response**	**Instructions to Complete**
7	YEAR 1 - Have you been an active Medicaid Provider with DHS for any 90 day period over the last calendar year?	YES OR NO	*If no, the provider is not eligible for provider incentive payment for this calendar year*
#	**Question**	**Response**	**Instructions to Complete**
8	YEARS 2-6. Were you an active Medicaid Provider with DHS during the entire calendar year last year in order to be eligible for MU demonstration during the full attestation period required by the regulations?	YES OR NO	*NOT APPLICABLE until the provider has attested for YEAR 2 incentive payment.* *If no, the provider is not eligible for provider incentive payment for this calendar year*
#	**Question**	**Response**	**Instructions to Complete**
9	Is your designated Pay to Provider in your Attestation worksheet an active Medicaid Provider with DHS?	YES OR NO	*Please note that providers should designate their pay to provider as a provider that is an active Medicaid Provider with a current Pay to Affiliation within the MMIS. Providers who are not set up as pay to provider within the system will not be able to receive a payment from the system. Should the provider wish to add themselves as a possible pay to provider within the MMIS solution, they will need to contact Medicaid Provider Services.855-248-7536*

Figure 2 - Eligible Provider Workbook - Provider Information

2.3 Eligible Provider Attestation Workbook – Medicaid Volume Information and Questions

The third tab of the workbook requests from the professional provider the Medicaid Volume requirements for the USVI Medicaid EHR Incentive payment program attestation.



USVI Electronic Health Record Provider Incentive Program
Professional Provider Attestation Worksheet

Practice Predominately at a Hospital

Providers must not predominately practice at hospitals in order to qualify for the incentive payment. Providers are considered to practice predominately at a hospital if more than 90% of their encounters are in a place of service of inpatient, outpatient hospital, or Emergency Room setting.	YES or NO

Volume Check - 90 Day Period (YEAR 1)

	Start Date	End Date
Provider must meet patient volume criteria for a 90 day period in the prior calendar year.		

INSTRUCTIONS: The provider must select a date range in the prior calendar year. Please note that the provider must be an active Medicaid provider during the selected time frame and have claims within the MMIS solution to validate their Medicaid volume attestation. The system will not let the provider select a date range that precedes the prior calendar year.

Use Another Group Practice or Clinic as Proxy for Patient Volume Encounter??

Providers may elect to use your group practice or clinic locations encounter to achieve the 30% Medicaid volume requirement for incentive payment. If the provider elects to use their group or clinic total (as their proxy for encounter volume), all providers within that practice or location must follow suit if they intend to attest for incentive payment and report their volume using the practice or clinic NPI accordingly.

EPs may use a clinic or group practice patient volume as a proxy for their own under three conditions:

1. The clinic or group practice patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);

2. There is an auditable data source to support the clinic's patient volume determination; and

3. As long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

PROXY PROVIDER NPI (if needed)	

INSTRUCTIONS: The NPI of the provider practice in which the attesting provider wishes to use for the encounter volume calculation using the given provider's NPI as the Pay To provider NPI on the claim. (SEE ABOVE FOR RULES ON SELECTION/USAGE OF PROXY)

Overall Medicaid Patient Volume	**Fee For Service**	**MCO Volume**
NUMERATOR - # of Medicaid individual encounters	***The USVI EHR Incentive Payment solution will validate the Fee for Service (FFS) encounter volume upon submission***	

INSTRUCTIONS: ENCOUNTER DEFINITION - An encounter should be reflected in the count as one or more claims for the same patient for the same rendering physician for the same Date of service (DOS). This should be a count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. This Includes: All Medicaid paid encounters including inpatient, outpatient, and emergency room services. The USVI Medicaid EHR Incentive Payment solution will process a report from the MMIS system to validate the FFS encounter count within the numerator.

DENOMINATOR - # of Total patient encounters (denominator)	

INSTRUCTIONS: This should be a report of all provider encounters regardless of payer source from the provider's Practice Management System (PMS).

For Providers Who Wish to Demonstrate they are Practicing Predominately in an FQHC/RHC who do not meet the Overall Medicaid Volume Requirements

	Start Date	End Date
Indicate what 6 month period(in the previous calendar year) that you, as a provider, practiced predominately at an FQHC/RHC (more than 50% of your patient encounters)		

NUMERATOR - Number of Patient Encounters at and FQHC/RHC during the time frame specified	
DENOMINATOR - Total Number of Patient Encounters for the Provider during the time period specified	

For Providers Attesting to having more than 50% Encounters at and FQHC/RHC (Number of Needy Patients)

NUMERATOR:	**NUMBER**
Number of Patients Receiving Medical Assistance from Medicaid	

DEFINITION: Services rendered on any one day to an individual where Medicaid or Medicaid demonstration project under section 1115 of ARRA paid for part or all of the service or paid all or part of their premiums, co-payments, and/or cost sharing.

Number of Patients Receiving Medical Assistance from CHIP	

DEFINITION: Services rendered on any one day to an individual where CHIP or CHIP demonstration project under section 1115 of ARRA paid for part or all of the service or paid all or part of their premiums, co-payments, and/or cost sharing.

Number of Patients furnished uncompensated care	

DEFINITION: Services rendered to an individual on any one day that were uncompensated.

Number of patients furnished services at either no cost or reduced cost based on sliding scale determined by the individual's ability to pay	

DEFINITION: Services rendered to an individual on any one day on a sliding scale.

SUM = Total Number of patient encounters an FQHC/RHC where the patient is a "Needy Individual"	0

DEFINITION: The system auto calculates this number from the sum above components to determine the full number of needy individual encounters for the provider

DENOMINATOR:	
Number of all patient encounters at the FQHC/RHC during the specified time period	

DEFINITION: This is the total number of patient encounters the FQHC/RHC had for the specified time frame based on reports from their practice management system

Figure 3 - Eligible Provider Workbook - Medicaid Volume

2.4 Eligible Provider Attestation Workbook – EHR Certification Information

The workbook requests from the professional provider the EHR Certification information requirements for the USVI Medicaid EHR Incentive payment program attestation and informs the user where to find the EHR Certification number for the EHR system.

USVI Electronic Health Record Provider Incentive Program

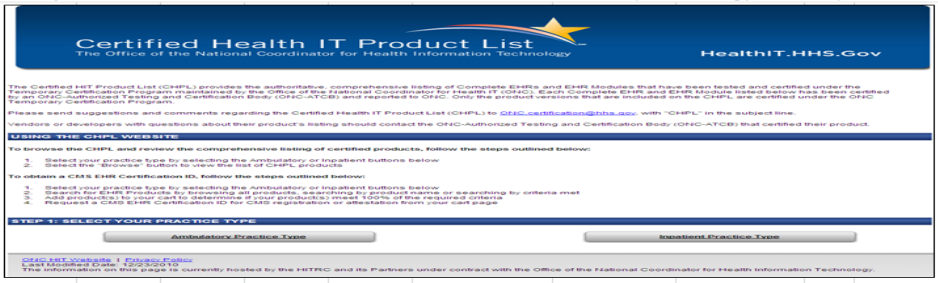
Professional Provider Attestation Worksheet

EHR Solution for Meaningful Use

Please select a 90 day period in the current year if you meet at least one of the following: *AIU *2013 Meaningful use *2014 Meaningful use	Start Date	End Date

CMS EHR Certification Number

INSTRUCTIONS: This is the ONC Certified Health IT Product List ID for your EHR system. Please review the web site below (http://onc-chpl.force.com/ehrcert) to obtain your EHR Certification number. The solution will check the ONC site to make sure this is a valid solution prior to allowing you to submit your attestation.


Certified Health IT Product List
The Office of the National Coordinator for Health Information Technology
HealthIT.HHS.Gov
USING THE CHPL WEBSITE
STEP 1: SELECT YOUR PRACTICE TYPE
Ambulatory Practice Type
Inpatient Practice Type

Adopt/Implement/Upgrade & Meaningful Use Status

Only in the first year of participation, and only in the Medicaid EHR Incentive Program, eligible professionals (EPs) and eligible hospitals can receive incentive payments through an option called "adopt, implement, or upgrade," commonly known as "AIU." The AIU option is offered in recognition of EPs and hospitals that may not be ready to "Meaningfully Use" certified EHR technology in the first payment year, and additionally, may require initial up-front resources to "adopt, implement, or upgrade" the certified EHR technology required to participate in the program.

Briefly, the EHR final rule and regulations define AIU as follows:

Adopt: To "acquire, purchase, or secure access to certified EHR technology."

There is evidence that a provider demonstrated actual installation prior to the incentive, rather than "efforts" to install. This evidence would serve to differentiate between activities that may not result in installation (for example, researching EHRs or interviewing EHR vendors) and actual purchase/acquisition or installation. Acquisition or purchase does not necessarily mean the certified EHR technology is installed and functioning.

Implementation: To "install or commence utilization of certified EHR technology."

The provider has installed certified EHR technology and has started using the certified EHR technology in his or her clinical practice. Implementation activities would include staff training in the certified EHR technology, the data entry of their patients' demographic data into the EHR, or establishing data exchange agreements and relationships between the provider's certified EHR technology and other providers, such as laboratories and pharmacies.

Upgrade: To "expand the available functionality of certified EHR technology."

The provider has added clinical decision support, e-prescribing functionality, or other enhancements that facilitate the meaningful use of certified EHR technology. An example of upgrading that would qualify for the EHR incentive payment would be upgrading from an existing EHR to a newer version that is certified per the EHR certification criteria promulgated by the Office of the National Coordinator (ONC) related to meaningful use. Upgrading may also mean expanding the functionality of an EHR in order to render it certifiable per the ONC EHR certification criteria (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__home/1204).

2013 Meaningful use

If your EHR Edition is either IF EHR is 2011 Edition or Combination of 2013 and 2014 Edition, you will be required to response to 2013 Meaningful use measures.

2014 Meaningful use

If your EHR Edition is either IF EHR is 2014 Edition or Combination of 2013 and 2014 Edition, you will be required to response to 2014 Meaningful use measures.

Field	Value	Description
Adopt/Implement/Upgrade	Select **Adopt, Implement or Upgrade** for YEAR 1 attestation.	See Definition Above for Help with Selection
2013 Meaningful Use	Meaningful Use (2013 Stage 1)	IF EHR is 2011 Edition or Combination of 2013 and 2014 Edition
2014 Meaningful Use	Meaningful Use (2014 Stage 1)	If EHR is 2014 EHR Edition or Combination of 2013 and 2014 Edition

Question required if not using a 2014 EHR Edition

Do you attest that you are unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability?

Yes or No	If yes, explain delay

Questions required regardless of EHR Edition

80% of patients information in an EHR

YES or NO

Did you practice at multiple practices or locations during your meaningful use reporting period?

YES or NO	If yes, obtain locations' information

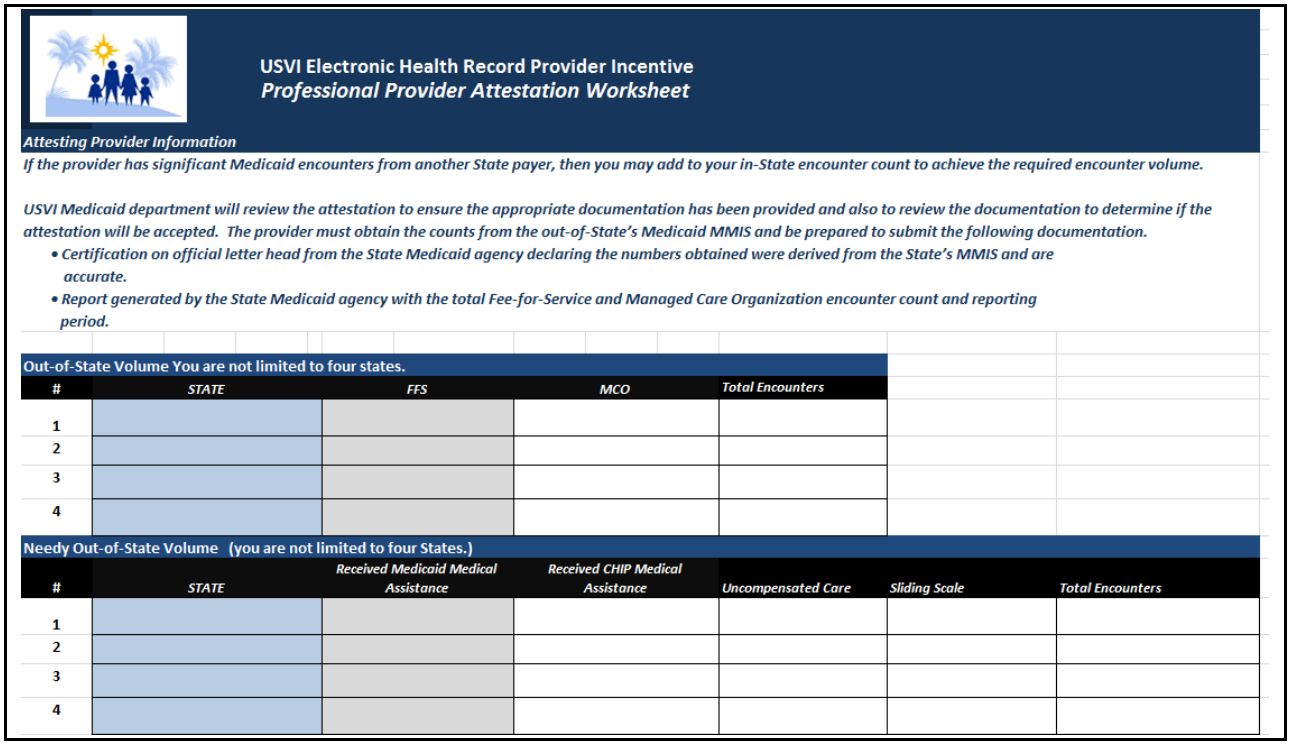
Practice Name	Practice Address	EHR Y/N	Total Encounters

COMMENT: An audit of your attestation may require you to produce documentation to prove the usage of the EMR/EHR solution attested to as well as it current usage/status.

Figure 4 - Eligible Provider Workbook - EHR Certification Number

2.5 *Eligible Provider Attestation Workbook – Out-of-State Volume Entries*

The fifth table of the worksheet captures the out-of-state volumes, which includes Needy Patient volume.



USVI Electronic Health Record Provider Incentive
Professional Provider Attestation Worksheet

Attesting Provider Information

If the provider has significant Medicaid encounters from another State payer, then you may add to your in-State encounter count to achieve the required encounter volume.

USVI Medicaid department will review the attestation to ensure the appropriate documentation has been provided and also to review the documentation to determine if the attestation will be accepted. The provider must obtain the counts from the out-of-State's Medicaid MMIS and be prepared to submit the following documentation.

- *Certification on official letter head from the State Medicaid agency declaring the numbers obtained were derived from the State's MMIS and are accurate.*
- *Report generated by the State Medicaid agency with the total Fee-for-Service and Managed Care Organization encounter count and reporting period.*

Out-of-State Volume You are not limited to four states.

#	STATE	FFS	MCO	Total Encounters
1				
2				
3				
4				

Needy Out-of-State Volume (you are not limited to four States.)

#	STATE	Received Medicaid Medical Assistance	Received CHIP Medical Assistance	Uncompensated Care	Sliding Scale	Total Encounters
1						
2						
3						
4						

Figure 5 - Eligible Provider Workbook - Out-of-State

2.6 *Eligible Provider Attestation Workbook – Meaningful Use Measures*

The remaining tabs in the workbook display the meaningful use Core Measures, the Menu Measures, and the Clinical Quality Measures that are required for attesting for meaningful use 2013 Stage 1 and 2014 Stage 1.

3. Required Supporting Documentation

CMS and DHS recommends documentation be retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by DHS or the U.S. Department of Health and Human Services (DHHS).

The provider must make all records and documentation available upon request to DHS and/or DHHS. Such records and documentation must include but not be limited to:

- ❑ Financial Records
- ❑ Practicing Provider Information (credentials)
- ❑ Identification of Service Sites
- ❑ Dates of Service for Each Service Component by Patient
- ❑ Patient Records
- ❑ Invoices/lease agreement supporting Adopt/Implementation/Utilization(AIU)
- ❑ EMR Reports supporting Meaningful Use attestation

If the provider plans to include encounter counts from another payer's state, the following documentation is required in an electronic format (pdf, Microsoft Word or Excel, or jpeg) and will need to be included with the electronic attestation.

- ❑ Certification on official letterhead from the state Medicaid agency declaring the numbers obtained were derived from the state's MMIS and are accurate.
- ❑ Report generated by the State Medicaid agency with the total Fee-for-Service, Medicaid Managed Care, and/or Managed Care Organization encounter count and reporting period.

Please review DHS requirements and applicable provider manuals for the specific service requirements, retention periods and lists.

OUT OF STATE DOCUMENTATION

If the EP plans to include encounter counts from another state (this is optional), the following documentation is required in an electronic format (pdf, Microsoft Word or Excel, or jpeg) and will need to be included with the electronic attestation:

- ❑ Certification on official letterhead from the other state Medicaid agency or agencies declaring the numbers obtained were derived from the State's MMIS and are accurate.

Report generated by the other state Medicaid agency or agencies with the total fee-for-service and managed care encounter count and reporting period.

4. Obtaining an United States Virgin Islands (USVI) Medicaid Management Information System (VIMMIS) Login

USVI Medicaid providers must first have an account in USVI Provider Web portal (www.vimmis.com) in order to gain access to the USVI Provider Incentive payment system.

To sign up for a login and password to the USVI Health PAS Online Provider portal, a Medicaid enrolled provider must visit https://www.vimmis.com or contact USVI Medicaid Provider Services staff at 855-248-7536 option 2.

5. Enrolling in USVI Medicaid

Healthcare providers supporting USVI Medicaid patients must be actively enrolled providers for the timeframe that they will attest to their Medicaid patient volume and Electronic Health Record usage as it pertains to meeting the regulations.

If the practicing provider meets the appropriate provider type and Medicaid volume requirements and is not actively enrolled as a USVI Medicaid provider, then the provider must enroll with Medicaid to proceed with USVI Medicaid EHR Provider Incentive payment application. Please contact the USVI Medicaid Provider Services Help Desk at 855-248-7536 option 3 between the hours of 8am and 5pm Eastern Standard Time. New providers that enroll in Medicaid will not be immediately eligible under the regulations and must wait the appropriate time to meet both the meaningful usage timeframes and Medicaid patient volume timeframes. Providers who have questions concerning the current enrollment status, enrollment dates and enrolled type and specialty may also contact this number for assistance with enrollment.

6. Determine If Intend to Use Group/Clinic Medicaid Volume to meet Medicaid Volume Requirements

Eligible Providers (EPs) may elect to use group practice or clinic locations encounter to achieve the Medicaid patient volume required to receive a USVI incentive payment. If the EP elects to use the group or clinic total as a proxy for their individual count, all EPs attesting from the practice or location **must** follow suit and use the group proxy volume as well.

EPs may use a clinic or group practice's patient volume as a proxy under three conditions:

1. The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);

2. There is an auditable data source to support the clinic's patient volume determination;

3. The practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works in both the clinic and outside the clinic (or with and outside a group practice), then the clinic/practice level determination includes only those encounters associated with the clinic/practice.

7. Finding EHR Certification Number

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) is the body that tests and certifies electronic health record (EHR) systems. If the EHR system is approved, it is assigned a certification number. The website below is the Certified Health IT Product List website, http://onc-chpl.force.com/ehrcert, to look up your certified EHR technologies (CEHRT), add them to the cart, and then check out to obtain an EHR Certification Number for your CEHRT.

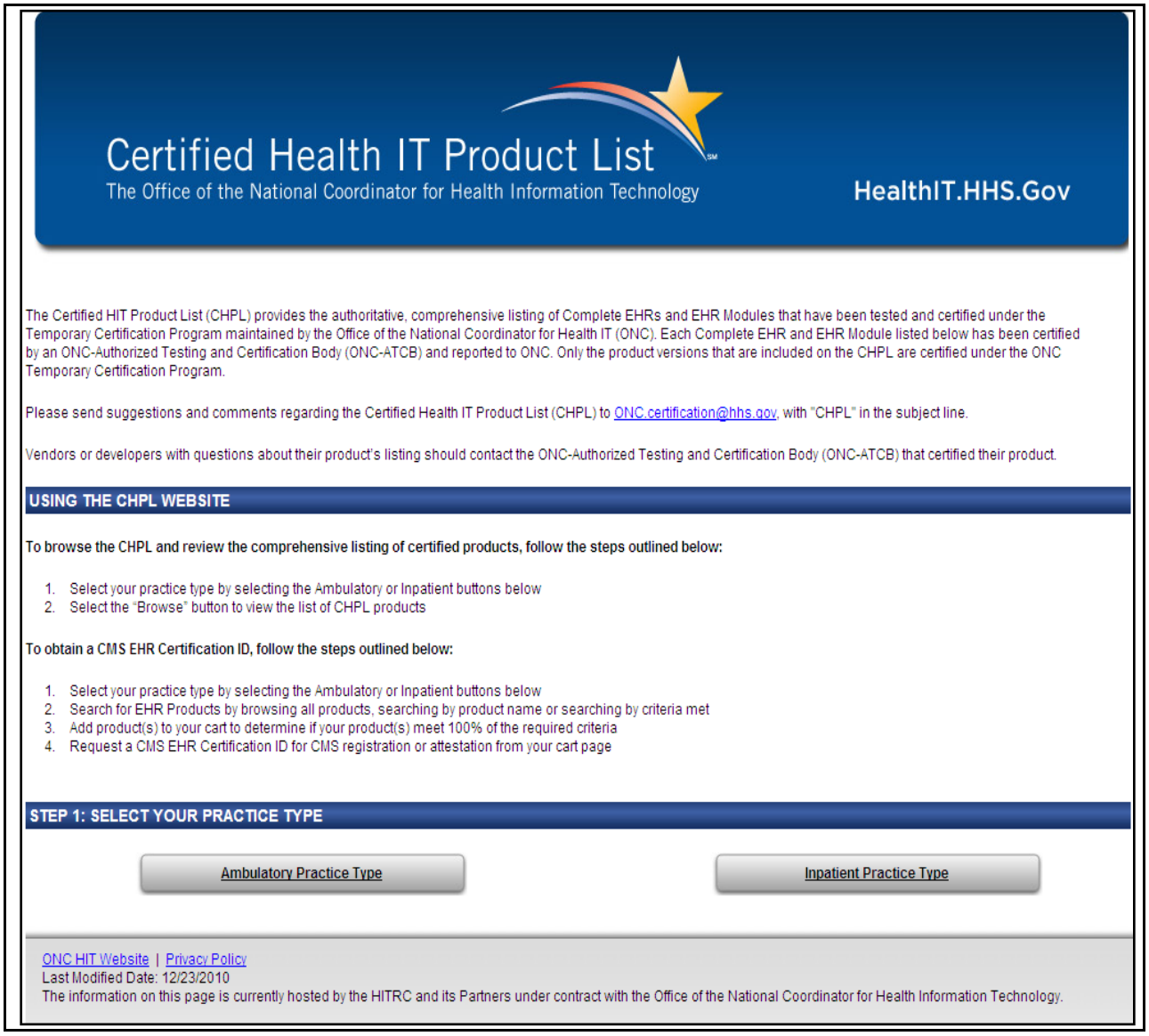

Certified Health IT Product List
The Office of the National Coordinator for Health Information Technology
HealthIT.HHS.Gov
The Certified HIT Product List (CHPL) provides the authoritative, comprehensive listing of Complete EHRs and EHR Modules that have been tested and certified under the Temporary Certification Program maintained by the Office of the National Coordinator for Health IT (ONC). Each Complete EHR and EHR Module listed below has been certified by an ONC-Authorized Testing and Certification Body (ONC-ATCB) and reported to ONC. Only the product versions that are included on the CHPL are certified under the ONC Temporary Certification Program.
Please send suggestions and comments regarding the Certified Health IT Product List (CHPL) to ONC.certification@hhs.gov, with "CHPL" in the subject line.
Vendors or developers with questions about their product's listing should contact the ONC-Authorized Testing and Certification Body (ONC-ATCB) that certified their product.
USING THE CHPL WEBSITE
To browse the CHPL and review the comprehensive listing of certified products, follow the steps outlined below:
1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Select the "Browse" button to view the list of CHPL products
To obtain a CMS EHR Certification ID, follow the steps outlined below:
1. Select your practice type by selecting the Ambulatory or Inpatient buttons below
2. Search for EHR Products by browsing all products, searching by product name or searching by criteria met
3. Add product(s) to your cart to determine if your product(s) meet 100% of the required criteria
4. Request a CMS EHR Certification ID for CMS registration or attestation from your cart page
STEP 1: SELECT YOUR PRACTICE TYPE
Ambulatory Practice Type
Inpatient Practice Type
ONC HIT Website | Privacy Policy
Last Modified Date: 12/23/2010
The information on this page is currently hosted by the HITRC and its Partners under contract with the Office of the National Coordinator for Health Information Technology.

Figure 6 - Certified health IT Product List site

8. System Requirements

To successfully use all features of the USVI Provider Incentive Program application, ensure that the computer system meets the following minimum requirements:

- PC has a reliable internet connection
- Web browser – The latest version of Microsoft® Internet Explorer is recommended (IE8.0 and higher). As new versions of Internet Explorer become available it is recommended that these versions are used.
- Adobe® Acrobat Reader.

9. Navigation

This section describes the navigation options that are available throughout the application.

9.1 Breadcrumbs

When a hyperlink is clicked, the appropriate web page is displayed to the right of the navigation bar. The breadcrumbs indicate the current position within the site. Breadcrumbs are a visual representation of pages and sub-pages followed to reach this page. Select the underlined name to return to the specific page. For the example screen, the breadcrumb translates to the following.

- The gray text that is not underlined in the breadcrumb indicates the current section. In this case it is the Meaningful Core Measures questions.
- The underlined text will display the page that it is assigned. For example:
    - Attest displays the "Attestation Topics" Page.
    - Attestations displays the "Attestation Selection" Page.

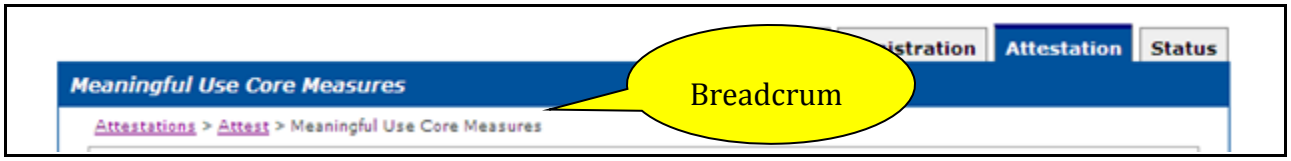


Figure 7 - Breadcrumbs

9.2 Use of the Navigation Features

Every window of the USVI Medicaid EHR Incentive Program has a set of standard navigation features. The features are located on the upper right-hand corner of the application. Refer to Figure 8.

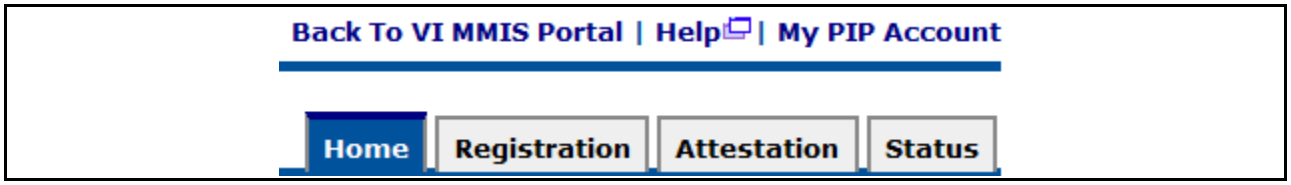


Figure 8 - Feature Description

9.2.1 Help Hyperlink

- Displays an electronic form of this document in a separate Internet Explorer window.

9.2.2 USVI Medicaid EHR Incentive Program Account Hyperlink

Displays a screen with an email address box. USVI Medicaid EHR Incentive Program will use this email address to send notifications regarding the attestations. You may enter a new address, or update an existing one. Save changes by selecting the **"Update"** button. Press the **"Cancel"** button and changes will not be saved.

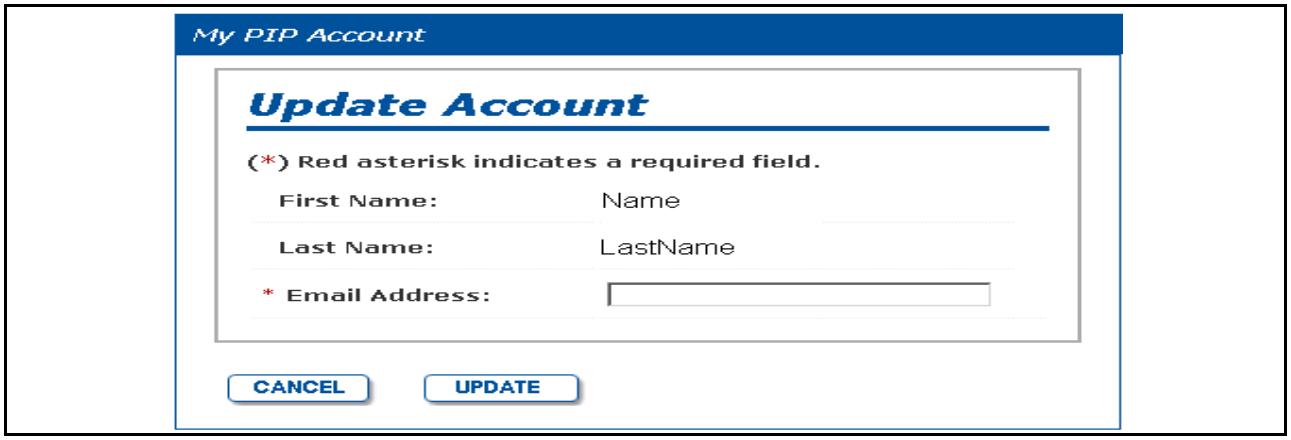


Figure 9 - Update Account Screen

9.2.3 Back to VI MMIS Portal

- Displays the VI MMIS Portal "Welcome" screen. Refer to Figure 16 USVI Welcome Screen.

9.2.4 Home Tab

- Displays the "Home" page as shown in Figure 10.

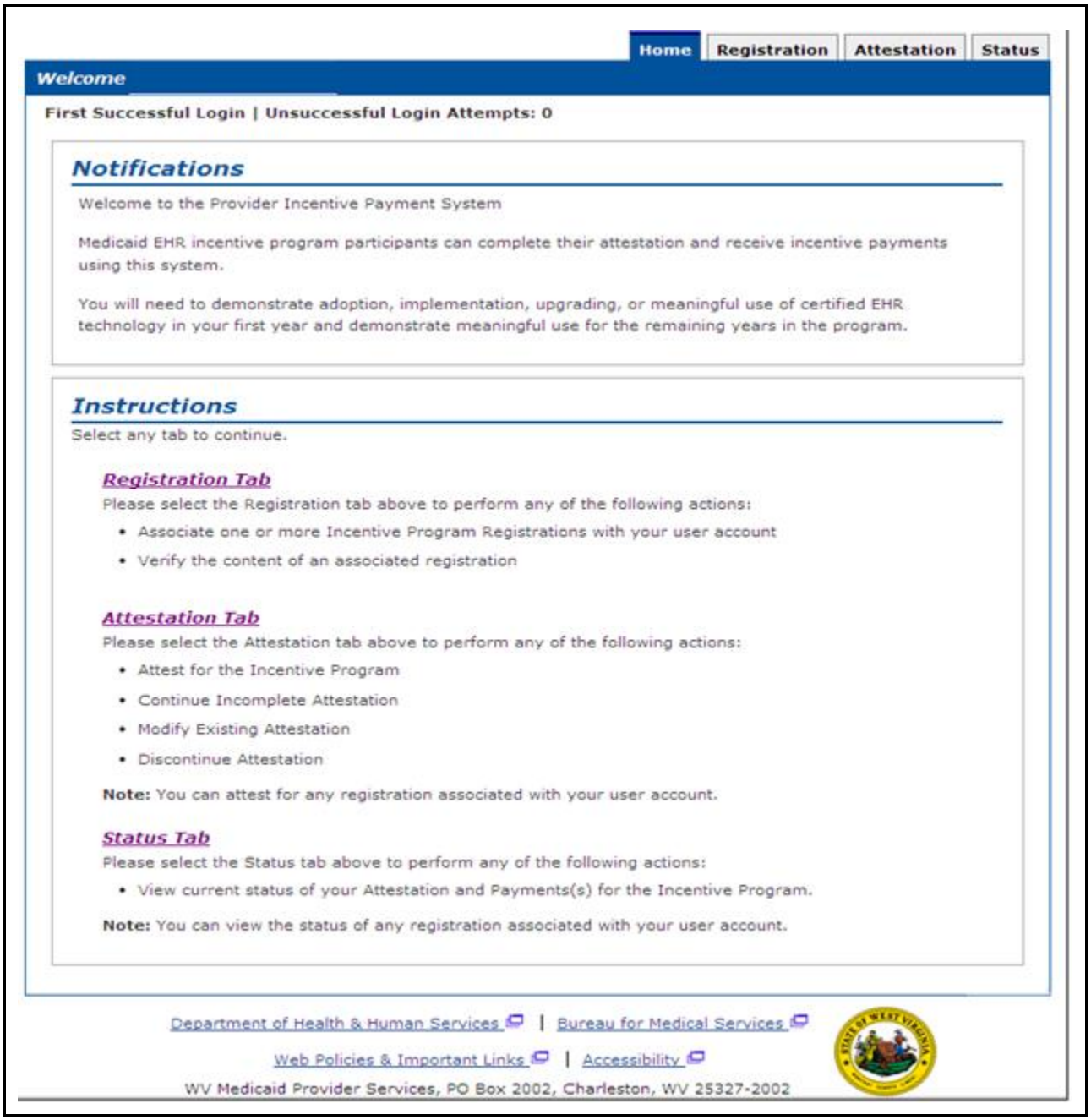

Home
Registration
Attestation
Status
Welcome
First Successful Login | Unsuccessful Login Attempts: 0
Notifications
Welcome to the Provider Incentive Payment System
Medicaid EHR incentive program participants can complete their attestation and receive incentive payments using this system.
You will need to demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology in your first year and demonstrate meaningful use for the remaining years in the program.
Instructions
Select any tab to continue.
Registration Tab
Please select the Registration tab above to perform any of the following actions:
Associate one or more Incentive Program Registrations with your user account
Verify the content of an associated registration
Attestation Tab
Please select the Attestation tab above to perform any of the following actions:
Attest for the Incentive Program
Continue Incomplete Attestation
Modify Existing Attestation
Discontinue Attestation
Note: You can attest for any registration associated with your user account.
Status Tab
Please select the Status tab above to perform any of the following actions:
View current status of your Attestation and Payments(s) for the Incentive Program.
Note: You can view the status of any registration associated with your user account.
Department of Health & Human Services | Bureau for Medical Services
Web Policies & Important Links | Accessibility
WV Medicaid Provider Services, PO Box 2002, Charleston, WV 25327-2002

Figure 10 - Home Page

9.2.5 Registration Tab

The *Registration* tab displays the "Registration Instruction" page. Refer to Figure 11.

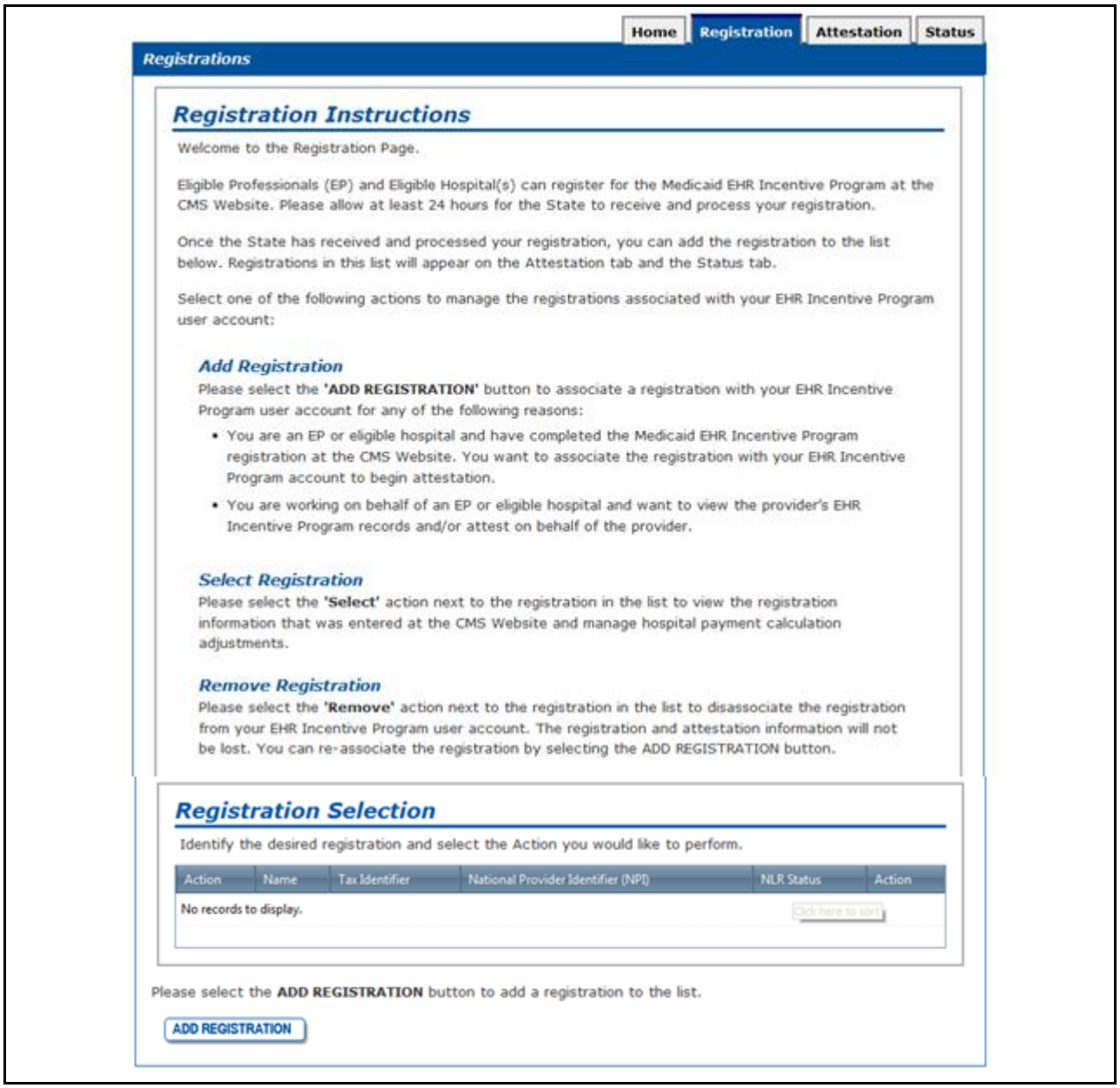

Home
Registration
Attestation
Status
Registrations
Registration Instructions
Welcome to the Registration Page.
Eligible Professionals (EP) and Eligible Hospital(s) can register for the Medicaid EHR Incentive Program at the CMS Website. Please allow at least 24 hours for the State to receive and process your registration.
Once the State has received and processed your registration, you can add the registration to the list below. Registrations in this list will appear on the Attestation tab and the Status tab.
Select one of the following actions to manage the registrations associated with your EHR Incentive Program user account:
Add Registration
Please select the 'ADD REGISTRATION' button to associate a registration with your EHR Incentive Program user account for any of the following reasons:
• You are an EP or eligible hospital and have completed the Medicaid EHR Incentive Program registration at the CMS Website. You want to associate the registration with your EHR Incentive Program account to begin attestation.
• You are working on behalf of an EP or eligible hospital and want to view the provider's EHR Incentive Program records and/or attest on behalf of the provider.
Select Registration
Please select the 'Select' action next to the registration in the list to view the registration information that was entered at the CMS Website and manage hospital payment calculation adjustments.
Remove Registration
Please select the 'Remove' action next to the registration in the list to disassociate the registration from your EHR Incentive Program user account. The registration and attestation information will not be lost. You can re-associate the registration by selecting the ADD REGISTRATION button.
Registration Selection
Identify the desired registration and select the Action you would like to perform.
Action
Name
Tax Identifier
National Provider Identifier (NPI)
NLR Status
Action
No records to display.
Click here to sort
Please select the ADD REGISTRATION button to add a registration to the list.
ADD REGISTRATION

Figure 11 – Registration Instructions Page

9.2.6 Attestation Tab

The *Attestation* tab displays the "Attestation Instructions" home page. Refer to Figure 12.

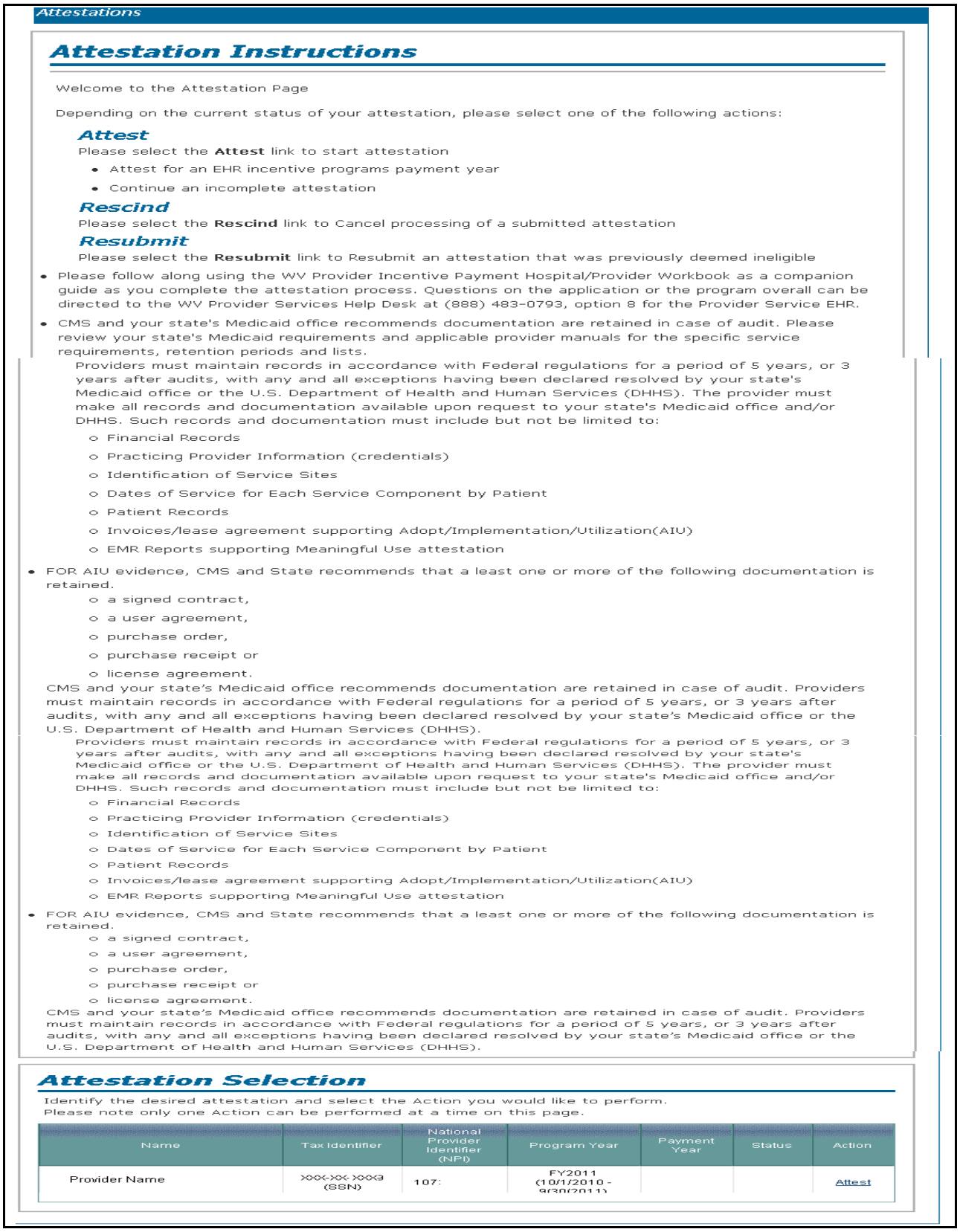

Attestations
Attestation Instructions
Welcome to the Attestation Page
Depending on the current status of your attestation, please select one of the following actions:
Attest
Please select the Attest link to start attestation
Attest for an EHR incentive programs payment year
Continue an incomplete attestation
Rescind
Please select the Rescind link to Cancel processing of a submitted attestation
Resubmit
Please select the Resubmit link to Resubmit an attestation that was previously deemed ineligible
Please follow along using the WV Provider Incentive Payment Hospital/Provider Workbook as a companion guide as you complete the attestation process. Questions on the application or the program overall can be directed to the WV Provider Services Help Desk at (888) 483-0793, option 8 for the Provider Service EHR.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Please review your state's Medicaid requirements and applicable provider manuals for the specific service requirements, retention periods and lists.
Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS). The provider must make all records and documentation available upon request to your state's Medicaid office and/or DHHS. Such records and documentation must include but not be limited to:
Financial Records
Practicing Provider Information (credentials)
Identification of Service Sites
Dates of Service for Each Service Component by Patient
Patient Records
Invoices/lease agreement supporting Adopt/Implementation/Utilization(AIU)
EMR Reports supporting Meaningful Use attestation
FOR AIU evidence, CMS and State recommends that a least one or more of the following documentation is retained.
a signed contract,
a user agreement,
purchase order,
purchase receipt or
license agreement.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS).
Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS). The provider must make all records and documentation available upon request to your state's Medicaid office and/or DHHS. Such records and documentation must include but not be limited to:
Financial Records
Practicing Provider Information (credentials)
Identification of Service Sites
Dates of Service for Each Service Component by Patient
Patient Records
Invoices/lease agreement supporting Adopt/Implementation/Utilization(AIU)
EMR Reports supporting Meaningful Use attestation
FOR AIU evidence, CMS and State recommends that a least one or more of the following documentation is retained.
a signed contract,
a user agreement,
purchase order,
purchase receipt or
license agreement.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS).
Attestation Selection
Identify the desired attestation and select the Action you would like to perform.
Please note only one Action can be performed at a time on this page.
Name
Tax Identifier
National Provider Identifier (NPI)
Program Year
Payment Year
Status
Action
Provider Name
XXX-XX-XXX3 (SSN)
107:
FY2011 (10/1/2010 - 9/30/2011)
Attest

Figure 12 - Attestation Instruction Page

9.2.7 The Standard Buttons

There are certain buttons found below the fields of each functional window that enables certain actions. The available actions depend on the purpose of the window. The most common buttons associated with USVI Medicaid EHR Incentive Payment Program are the **"Previous Page"** and the **"Save and Continue"** buttons. The **"Previous Page"** button displays the previous page in page sequence. The **"Save and Continue"** button must be selected. If not, any entries in the window are lost and must be reentered. The **"Submit"** button is also an option and is used when the user is ready to submit the answers for review and possible payment. Refer to Figure 13.

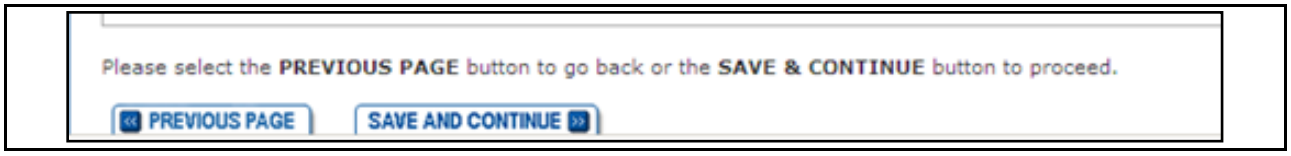

Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 13 - Standard Buttons

10. Using the USVI Medicaid EHR Incentive Program Application

The USVI Medicaid EHR Incentive Program application guides the user through the CMS required questions to determine if a provider is eligible to receive provider incentive payments. A workbook that contains the questions and the rules outlined by CMS is available and provides areas where answers may be recorded. An eligible provider may enter the information or assign someone to enter the information on their behalf.

The list below contains the different sections. Each section is discussed in detail.

- ❑ Pre-eligibility Checks, which is done on the receipt of a registration ID from CMS.
- ❑ Login instructions
- ❑ How to Register an EP
- ❑ Entry of Eligibility responses
    - ❑ Respond to practice setting
    - ❑ Respond with Medicaid volume and determine if the amount is accurate. If not, then determine if certain criteria are met.
- ❑ Payment Schedule
- ❑ Entry of CMS EHR information
    - ❑ If meaningful use selected, entry of meaningful use objectives and clinical quality measures information
- ❑ Submit Attestation

The figure below is a pictorial view of the USVI Medicaid EHR Incentive Program application steps.

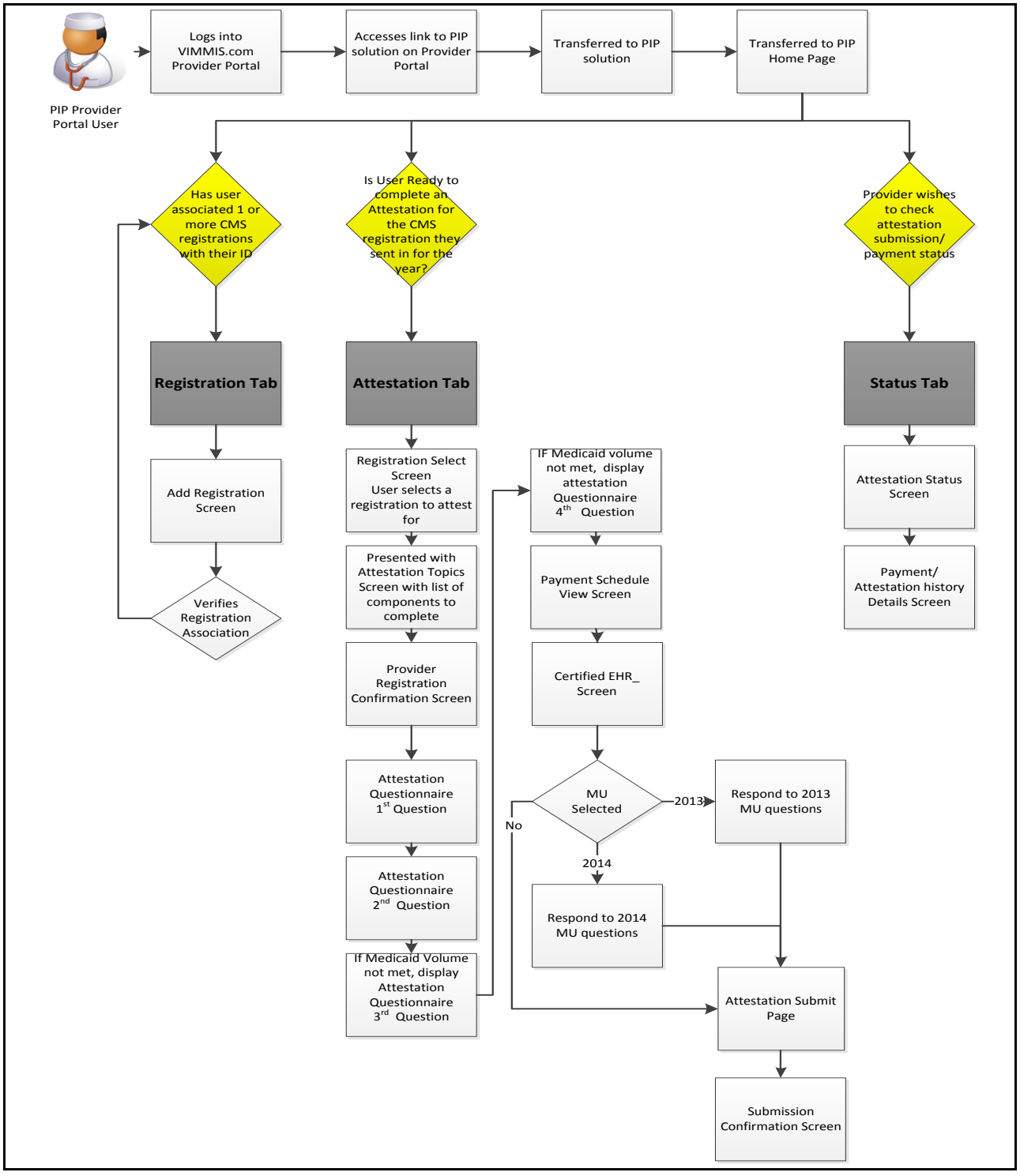

PIP Provider Portal User
Logs into VIMMIS.com Provider Portal
Accesses link to PIP solution on Provider Portal
Transferred to PIP solution
Transferred to PIP Home Page
Has user associated 1 or more CMS registrations with their ID
Is User Ready to complete an Attestation for the CMS registration they sent in for the year?
Provider wishes to check attestation submission/ payment status
Registration Tab
Attestation Tab
Status Tab
Add Registration Screen
Verifies Registration Association
Registration Select Screen User selects a registration to attest for
Presented with Attestation Topics Screen with list of components to complete
Provider Registration Confirmation Screen
Attestation Questionnaire 1st Question
Attestation Questionnaire 2nd Question
If Medicaid Volume not met, display Attestation Questionnaire 3rd Question
IF Medicaid volume not met, display attestation Questionnaire 4th Question
Payment Schedule View Screen
Certified EHR_ Screen
MU Selected
2013
2014
No
Respond to 2013 MU questions
Respond to 2014 MU questions
Attestation Submit Page
Submission Confirmation Screen
Attestation Status Screen
Payment/ Attestation history Details Screen

Figure 14 - Attestation Flowchart

10.1 Pre-eligibility check on receipt of CMS registration ID

When a registration is completed on the CMS NLR site, the registration information is sent to the USVI Medicaid EHR Incentive Program application. The system will receive the registration and execute the following checks. The end result is that the pre-eligibility checks will determine if the provider is eligible or not.

The system will access the provider's Medicaid Enrollment records that are stored within the databases to determine if the provider is actively enrolled in the Medicaid program.

Enrollment Check

- The solution will check if the provider was actively enrolled in Medicaid for the attestation period. The attestation period is 90 days for AIU, 90 days for the first year of MU, and the entire calendar for all other MU years.

Provider Type Specialty Check

Actively enrolled as Medicaid Providers with USVI Medicaid **with one of the below provider types/specialties:**

- Physicians (primarily doctors of medicine and doctors of osteopathy)
- Nurse practitioner
- Certified nurse-midwife
- Dentist
- Physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant.

The provider must meet the system's preliminary eligibility checks to be eligible to continue with attestation for Incentive Payment. If these checks are not met, the provider is considered to be ineligible.

The USVI Medicaid EHR Incentive Payment Solution will send the CMS NLR an update file with the preliminary determined eligibility status of the provider for the Incentive Program under Medicaid. It will also send an email indicating the status of the USVI Provider's Medicaid registration eligibility check to the email address that was entered during registration. This email will indicate eligibility status from these eligibility checks. If the status shows the provider is ineligible, the email will contain the eligibility checks that were not met and information on contacting the USVI Provider Services Help Desk if the provider feels this is in error.

If the USVI Medicaid EHR Incentive Payment solution finds the provider ineligible, a user attempting to add the provider's registration to the user account to continue the application process for EHR Incentive payment will not be able to add the registration for the ineligible provider. The system prevents the provider from continuing with the attestation process unless the status is found to be eligible.

At this point, USVI Provider Services representatives will have the ability to review and determine if the systematic eligibility status is valid or invalid for the provider. Providers may contact the USVI Provider Services Help Desk to assist with the denial of the registration. USVI Medicaid Provider Services Help Desk may be contacted at 855-248-7536 option 2 between the hours of 8am and 5pm EST.

The provider will then work with the representative via phone/email regarding the registration eligibility status and may be asked to resubmit registration with the NLR to proceed. Depending on the situation, the provider services representatives may also be able to override the system and manually approve the provider's eligibility and allow the provider to attest.

10.2 Login to the USVI Medicaid EHR Incentive Solution

This section provides instructions on how to start the USVI Medicaid EHR Incentive Solution application and logging into the system to use the application. Please obtain authorization from the registering provider to enter the data on their behalf.

10.2.1 Starting USVI Medicaid EHR Incentive Program application

The application runs on the Internet. Execute the following steps to start the application.

1. Access the VIMMIS.com main page. As shown in the figure below:

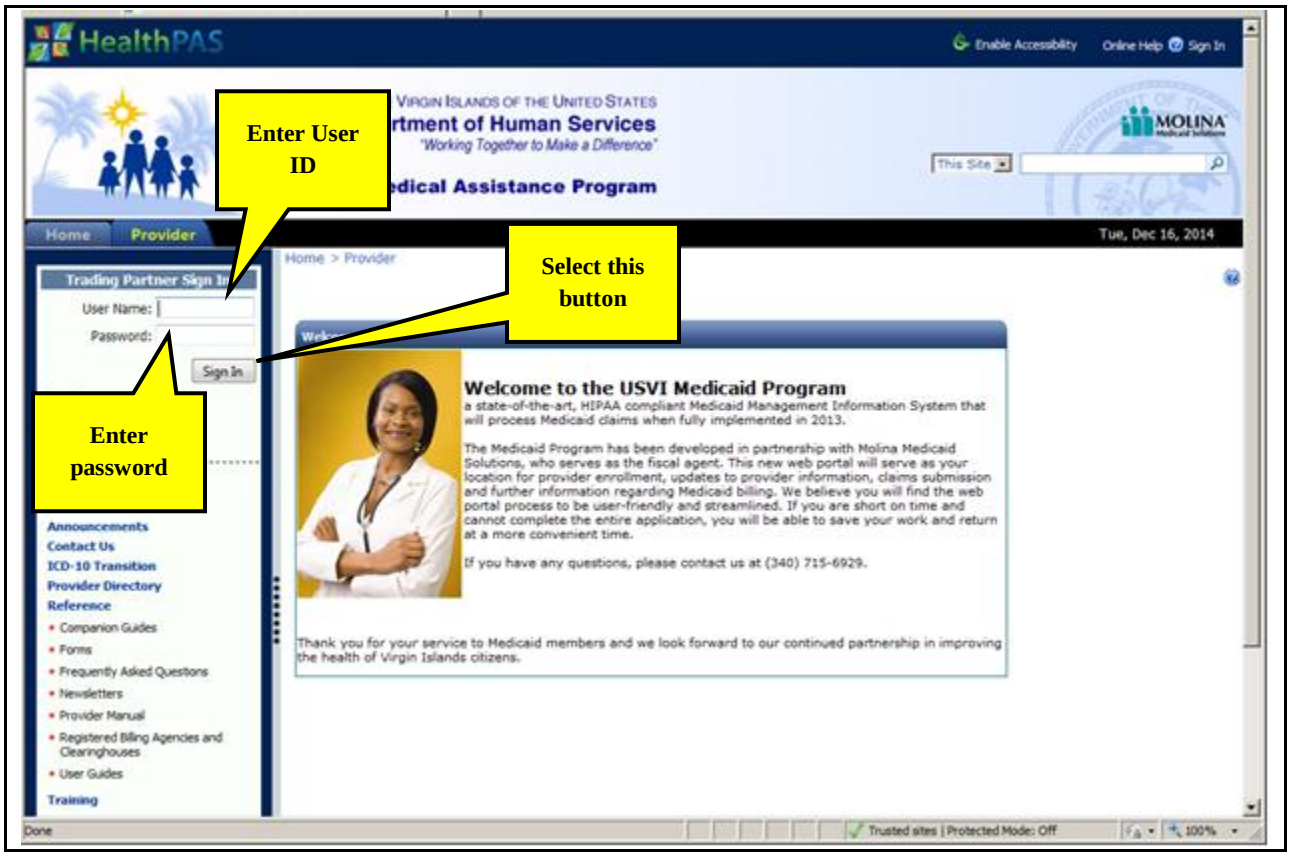

Enter User ID
Select this button
Enter password
HealthPAS
Enable Accessibility
Online Help
Sign In
Virgin Islands of the United States
rtment of Human Services
"Working Together to Make a Difference"
dical Assistance Program
MOLINA
Home
Provider
Tue, Dec 16, 2014
Home > Provider
Trading Partner Sign In
User Name:
Password:
Sign In
Welcome to the USVI Medicaid Program
a state-of-the-art, HIPAA compliant Medicaid Management Information System that will process Medicaid claims when fully implemented in 2013.
The Medicaid Program has been developed in partnership with Molina Medicaid Solutions, who serves as the fiscal agent. This new web portal will serve as your location for provider enrollment, updates to provider information, claims submission and further information regarding Medicaid billing. We believe you will find the web portal process to be user-friendly and streamlined. If you are short on time and cannot complete the entire application, you will be able to save your work and return at a more convenient time.
If you have any questions, please contact us at (340) 715-6929.
Thank you for your service to Medicaid members and we look forward to our continued partnership in improving the health of Virgin Islands citizens.
Announcements
Contact Us
ICD-10 Transition
Provider Directory
Reference
Companion Guides
Forms
Frequently Asked Questions
Newsletters
Provider Manual
Registered Billing Agencies and Clearinghouses
User Guides
Training
Done
Trusted sites | Protected Mode: Off
100%

Figure 15 - USVI Login Screen

2. Prepare to Logon by entering in Logon Name and Password in the appropriate entry boxes and select **Submit**

    - Enter Provider Web portal user ID.
    - Enter Provider Web portal password.
    - Select **Submit** button.

3. On the **Welcome** window, select the **USVI EHR Incentive Program** option to display the **Provider Incentive Program About This Site** page. Refer to Figure 17.

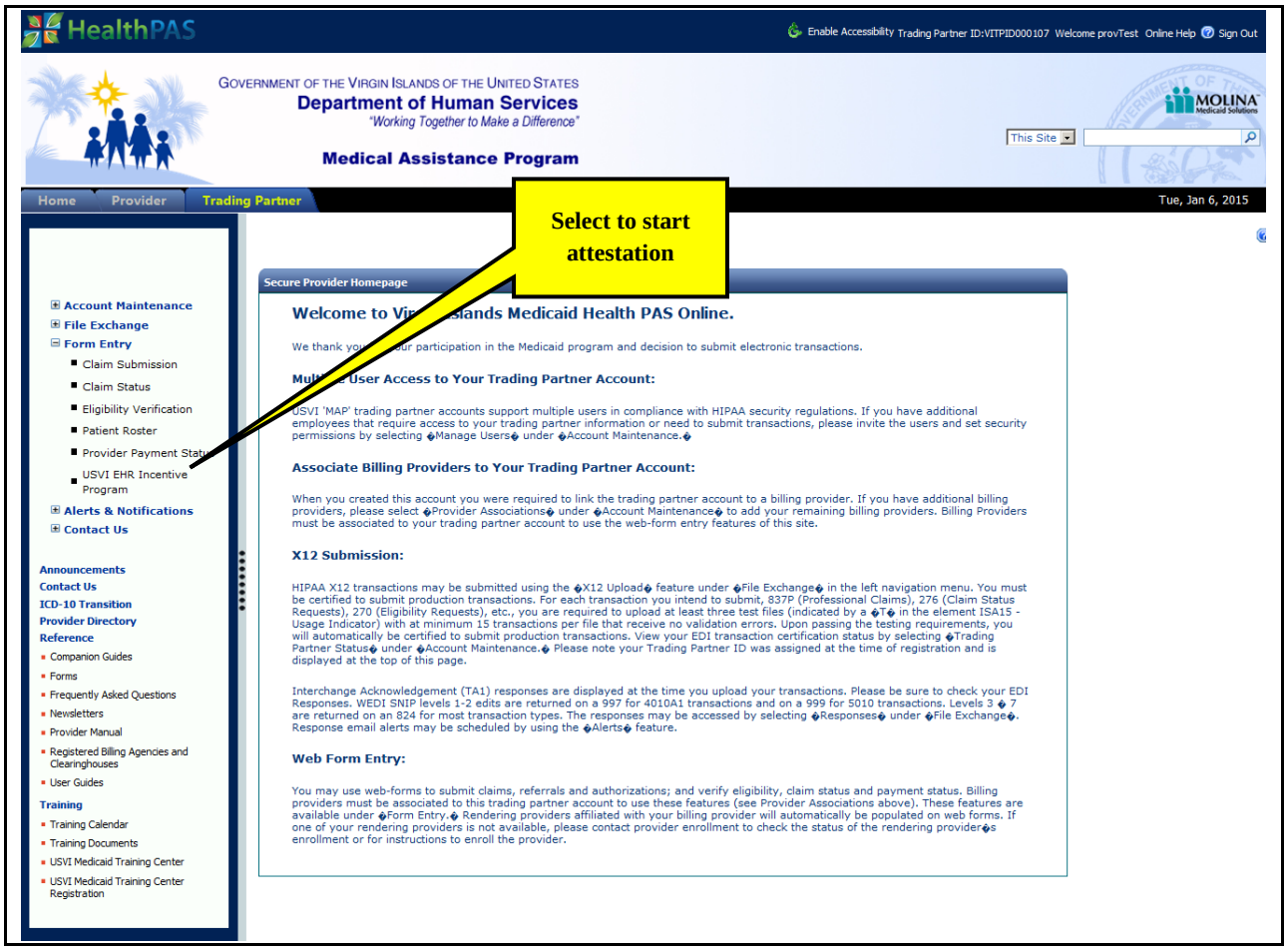

HealthPAS
Enable Accessibility Trading Partner ID:VITPID000107 Welcome provTest Online Help Sign Out
GOVERNMENT OF THE VIRGIN ISLANDS OF THE UNITED STATES
Department of Human Services
"Working Together to Make a Difference"
Medical Assistance Program
MOLINA Medicaid Solutions
This Site
Home
Provider
Trading Partner
Tue, Jan 6, 2015
Select to start attestation
Account Maintenance
File Exchange
Form Entry
Claim Submission
Claim Status
Eligibility Verification
Patient Roster
Provider Payment Status
USVI EHR Incentive Program
Alerts & Notifications
Contact Us
Announcements
Contact Us
ICD-10 Transition
Provider Directory
Reference
Companion Guides
Forms
Frequently Asked Questions
Newsletters
Provider Manual
Registered Billing Agencies and Clearinghouses
User Guides
Training
Training Calendar
Training Documents
USVI Medicaid Training Center
USVI Medicaid Training Center Registration
Secure Provider Homepage
Welcome to Virgin Islands Medicaid Health PAS Online.
We thank you for your participation in the Medicaid program and decision to submit electronic transactions.
Multiple User Access to Your Trading Partner Account:
USVI 'MAP' trading partner accounts support multiple users in compliance with HIPAA security regulations. If you have additional employees that require access to your trading partner information or need to submit transactions, please invite the users and set security permissions by selecting "Manage Users" under "Account Maintenance."
Associate Billing Providers to Your Trading Partner Account:
When you created this account you were required to link the trading partner account to a billing provider. If you have additional billing providers, please select "Provider Associations" under "Account Maintenance" to add your remaining billing providers. Billing Providers must be associated to your trading partner account to use the web-form entry features of this site.
X12 Submission:
HIPAA X12 transactions may be submitted using the "X12 Upload" feature under "File Exchange" in the left navigation menu. You must be certified to submit production transactions. For each transaction you intend to submit, 837P (Professional Claims), 276 (Claim Status Requests), 270 (Eligibility Requests), etc., you are required to upload at least three test files (indicated by a "T" in the element ISA15 - Usage Indicator) with at minimum 15 transactions per file that receive no validation errors. Upon passing the testing requirements, you will automatically be certified to submit production transactions. View your EDI transaction certification status by selecting "Trading Partner Status" under "Account Maintenance." Please note your Trading Partner ID was assigned at the time of registration and is displayed at the top of this page.
Interchange Acknowledgement (TA1) responses are displayed at the time you upload your transactions. Please be sure to check your EDI Responses. WEDI SNIP levels 1-2 edits are returned on a 997 for 4010A1 transactions and on a 999 for 5010 transactions. Levels 3 - 7 are returned on an 824 for most transaction types. The responses may be accessed by selecting "Responses" under "File Exchange". Response email alerts may be scheduled by using the "Alerts" feature.
Web Form Entry:
You may use web-forms to submit claims, referrals and authorizations; and verify eligibility, claim status and payment status. Billing providers must be associated to this trading partner account to use these features (see Provider Associations above). These features are available under "Form Entry." Rendering providers affiliated with your billing provider will automatically be populated on web forms. If one of your rendering providers is not available, please contact provider enrollment to check the status of the rendering provider's enrollment or for instructions to enroll the provider.

Figure 16 - USVI Welcome Screen

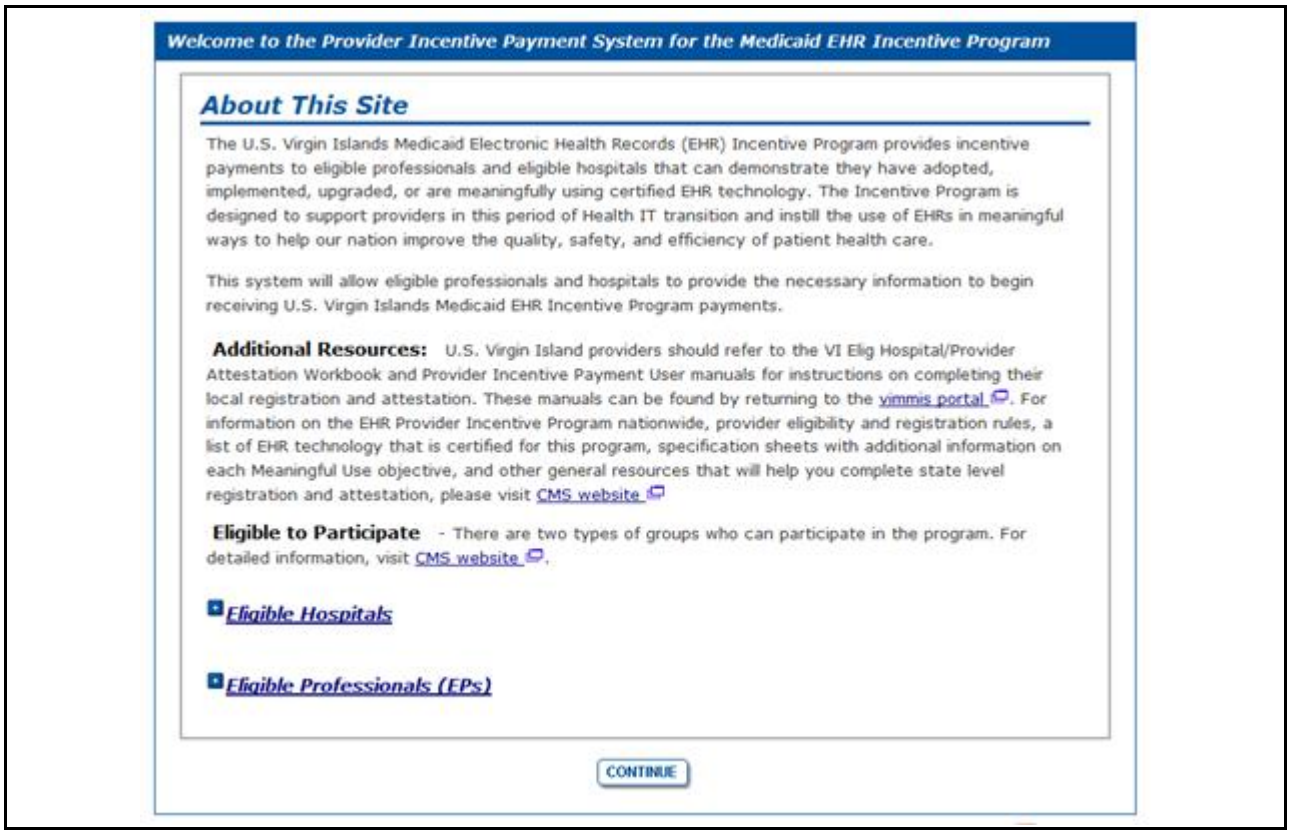

Welcome to the Provider Incentive Payment System for the Medicaid EHR Incentive Program
About This Site
The U.S. Virgin Islands Medicaid Electronic Health Records (EHR) Incentive Program provides incentive payments to eligible professionals and eligible hospitals that can demonstrate they have adopted, implemented, upgraded, or are meaningfully using certified EHR technology. The Incentive Program is designed to support providers in this period of Health IT transition and instill the use of EHRs in meaningful ways to help our nation improve the quality, safety, and efficiency of patient health care.
This system will allow eligible professionals and hospitals to provide the necessary information to begin receiving U.S. Virgin Islands Medicaid EHR Incentive Program payments.
Additional Resources: U.S. Virgin Island providers should refer to the VI Elig Hospital/Provider Attestation Workbook and Provider Incentive Payment User manuals for instructions on completing their local registration and attestation. These manuals can be found by returning to the vimmis portal. For information on the EHR Provider Incentive Program nationwide, provider eligibility and registration rules, a list of EHR technology that is certified for this program, specification sheets with additional information on each Meaningful Use objective, and other general resources that will help you complete state level registration and attestation, please visit CMS website
Eligible to Participate - There are two types of groups who can participate in the program. For detailed information, visit CMS website.
Eligible Hospitals
Eligible Professionals (EPs)
CONTINUE

Figure 17 - Provider Incentive About this Site Page

4. On the **Provider Incentive About This Site page**, select the **Continue** button to display the **Provider Incentive Program Notifications page**. Refer to Figure 18.

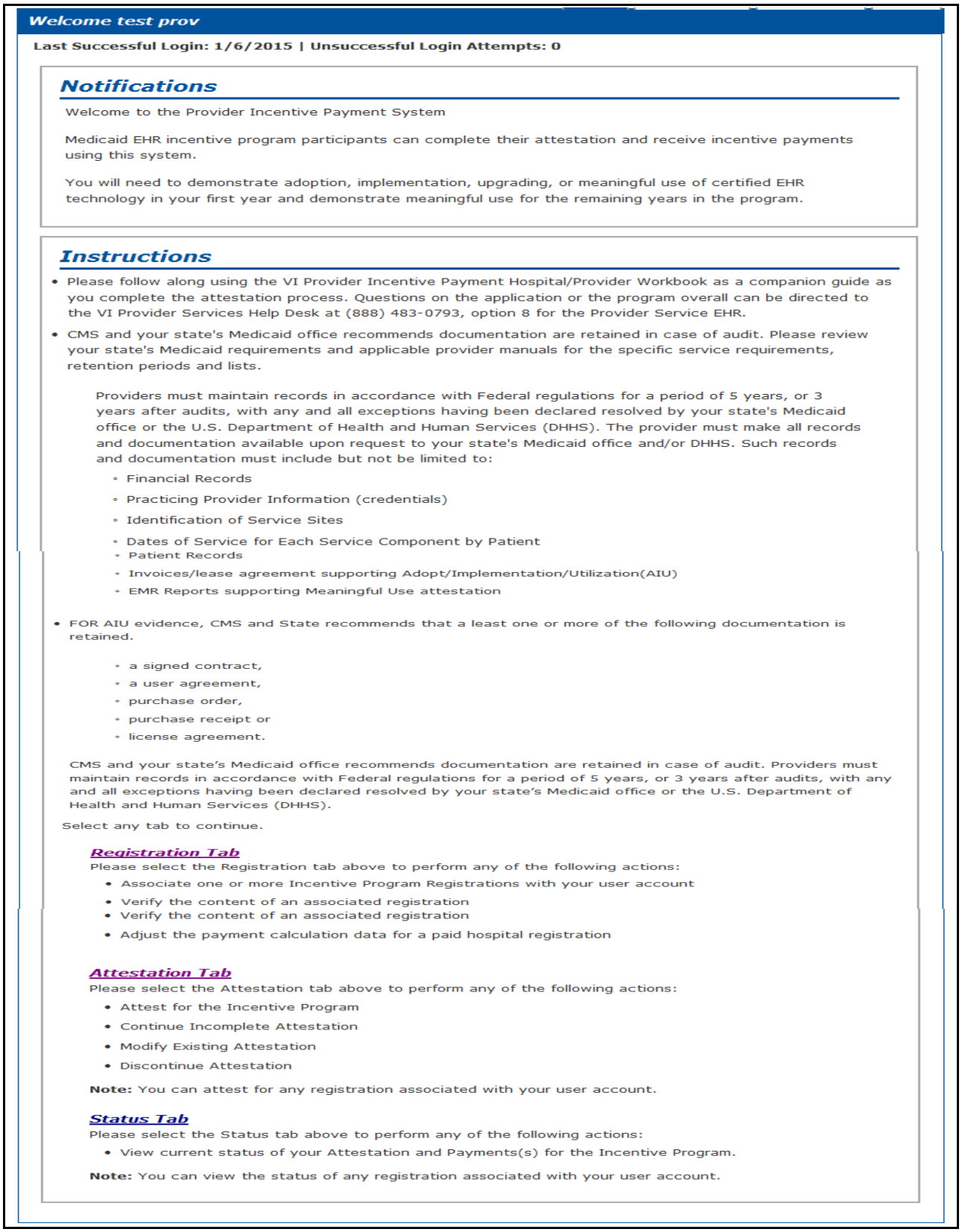

Welcome test prov
Last Successful Login: 1/6/2015 | Unsuccessful Login Attempts: 0
Notifications
Welcome to the Provider Incentive Payment System
Medicaid EHR incentive program participants can complete their attestation and receive incentive payments using this system.
You will need to demonstrate adoption, implementation, upgrading, or meaningful use of certified EHR technology in your first year and demonstrate meaningful use for the remaining years in the program.
Instructions
Please follow along using the VI Provider Incentive Payment Hospital/Provider Workbook as a companion guide as you complete the attestation process. Questions on the application or the program overall can be directed to the VI Provider Services Help Desk at (888) 483-0793, option 8 for the Provider Service EHR.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Please review your state's Medicaid requirements and applicable provider manuals for the specific service requirements, retention periods and lists.
Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS). The provider must make all records and documentation available upon request to your state's Medicaid office and/or DHHS. Such records and documentation must include but not be limited to:
Financial Records
Practicing Provider Information (credentials)
Identification of Service Sites
Dates of Service for Each Service Component by Patient
Patient Records
Invoices/lease agreement supporting Adopt/Implementation/Utilization(AIU)
EMR Reports supporting Meaningful Use attestation
FOR AIU evidence, CMS and State recommends that a least one or more of the following documentation is retained.
a signed contract,
a user agreement,
purchase order,
purchase receipt or
license agreement.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS).
Select any tab to continue.
Registration Tab
Please select the Registration tab above to perform any of the following actions:
Associate one or more Incentive Program Registrations with your user account
Verify the content of an associated registration
Verify the content of an associated registration
Adjust the payment calculation data for a paid hospital registration
Attestation Tab
Please select the Attestation tab above to perform any of the following actions:
Attest for the Incentive Program
Continue Incomplete Attestation
Modify Existing Attestation
Discontinue Attestation
Note: You can attest for any registration associated with your user account.
Status Tab
Please select the Status tab above to perform any of the following actions:
View current status of your Attestation and Payments(s) for the Incentive Program.
Note: You can view the status of any registration associated with your user account.

Figure 18 - Home Page

10.3 Registering a Provider within USVI Medicaid EHR Incentive Program

A registration number is a key component to the process. It is used along with the National Provider Identifier (NPI) to uniquely identify the provider. It is used within the CMS NLR environment to identify the provider and the provider incentive status. A registration ID is required in order to register and execute the attestation steps. A registration ID is obtained after using the CMS website to register the provider. The URL to CMS registration site is below. Please contact CMS if additional help is needed when using this URL.

- https://ehrincentives.cms.gov/hitech/login.action

After executing the CMS registration process, **please wait at least 48 hours** before executing this step. This allows CMS time to send the information to the USVI Medicaid EHR Incentive Program Attestation Application.

The Register tab allows the user to associate one or more provider registrations to the VIMMIS.com account, view registration IDs that are attached to the VIMMIS.com account, and detach any provider registrations from the VIMMIS.com account. Please obtain authorization from the provider to enter the data on his behalf.

Registering the provider must be done before the user is allowed to attest. This step ensures that only the appropriate individual has access to the provider's information and can enter the data needed for attestation.

1. To view, add, and remove registrations, click the *Registration* tab on the navigation bar.

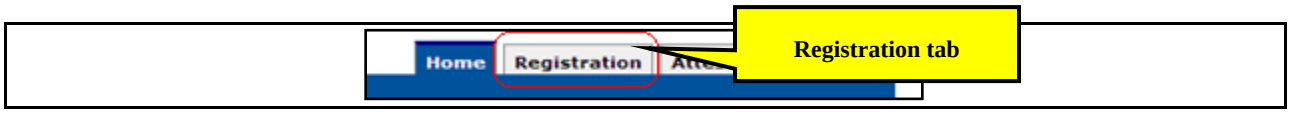


Figure 19 - Registration Tab

2. The "Registration" Home Page displays. Refer to Figure 20.

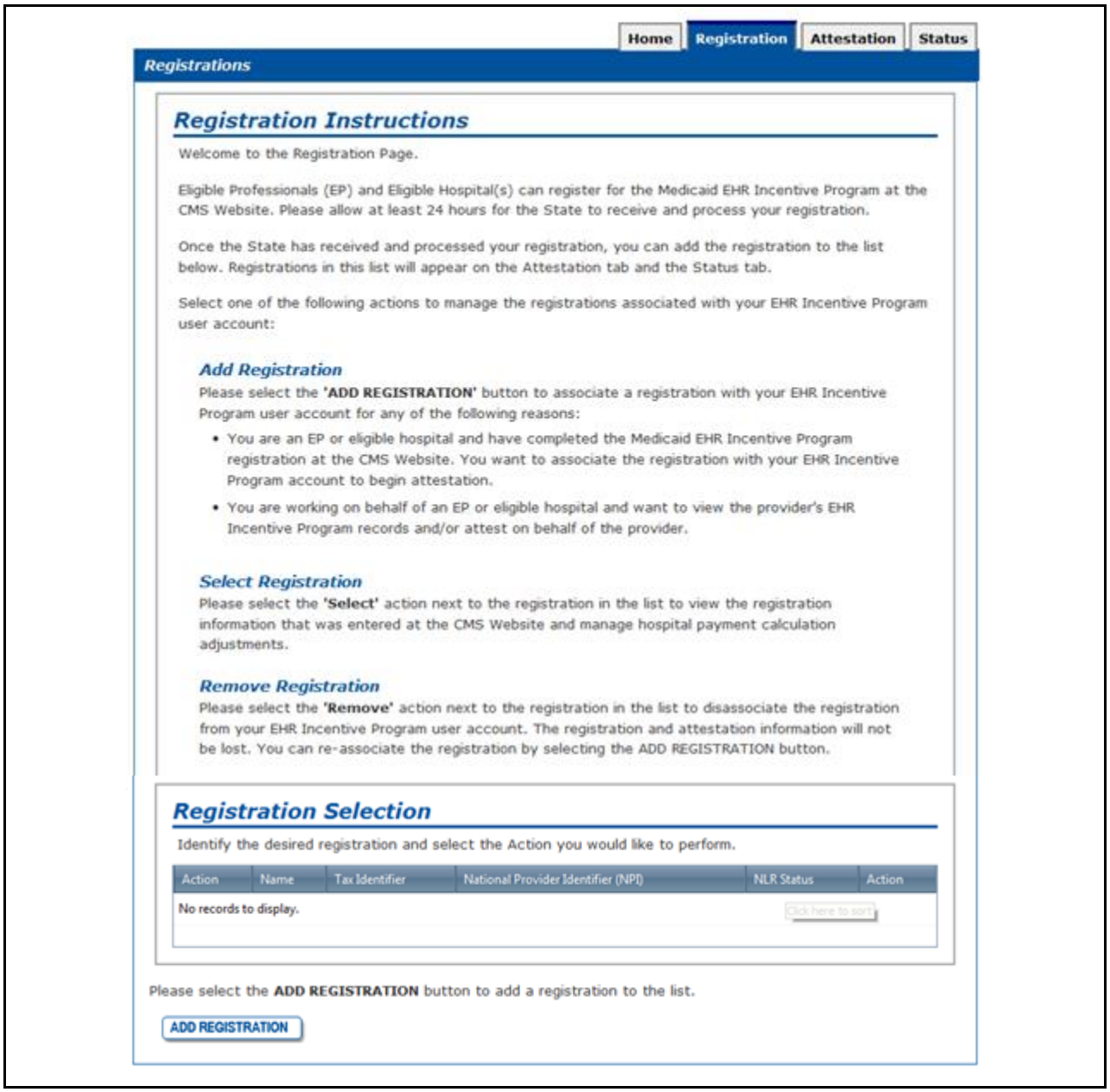

Home
Registration
Attestation
Status
Registrations
Registration Instructions
Welcome to the Registration Page.
Eligible Professionals (EP) and Eligible Hospital(s) can register for the Medicaid EHR Incentive Program at the CMS Website. Please allow at least 24 hours for the State to receive and process your registration.
Once the State has received and processed your registration, you can add the registration to the list below. Registrations in this list will appear on the Attestation tab and the Status tab.
Select one of the following actions to manage the registrations associated with your EHR Incentive Program user account:
Add Registration
Please select the 'ADD REGISTRATION' button to associate a registration with your EHR Incentive Program user account for any of the following reasons:
You are an EP or eligible hospital and have completed the Medicaid EHR Incentive Program registration at the CMS Website. You want to associate the registration with your EHR Incentive Program account to begin attestation.
You are working on behalf of an EP or eligible hospital and want to view the provider's EHR Incentive Program records and/or attest on behalf of the provider.
Select Registration
Please select the 'Select' action next to the registration in the list to view the registration information that was entered at the CMS Website and manage hospital payment calculation adjustments.
Remove Registration
Please select the 'Remove' action next to the registration in the list to disassociate the registration from your EHR Incentive Program user account. The registration and attestation information will not be lost. You can re-associate the registration by selecting the ADD REGISTRATION button.
Registration Selection
Identify the desired registration and select the Action you would like to perform.
Action
Name
Tax Identifier
National Provider Identifier (NPI)
NLR Status
Action
No records to display.
Please select the ADD REGISTRATION button to add a registration to the list.
ADD REGISTRATION

Figure 20 - Registration Tab - Registration Home Page

3. The "Registration" Home Page lists all registrations that you have added. If you have not added any, the Registration Selection section will display "No records to display" as shown in the figure below.

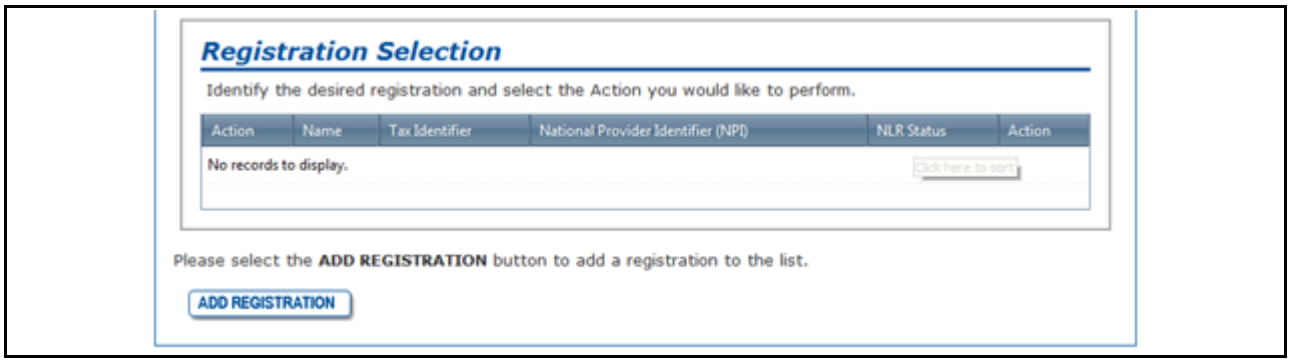

Registration Selection
Identify the desired registration and select the Action you would like to perform.
Action
Name
Tax Identifier
National Provider Identifier (NPI)
NLR Status
Action
No records to display.
Please select the ADD REGISTRATION button to add a registration to the list.
ADD REGISTRATION

Figure 21 - Registration Tab - No records to display

The sections below explains the options that are available on the "Registration" Home Page, which are "Add Registration"," Select", and "Remove".

10.3.1 Registration – Add option

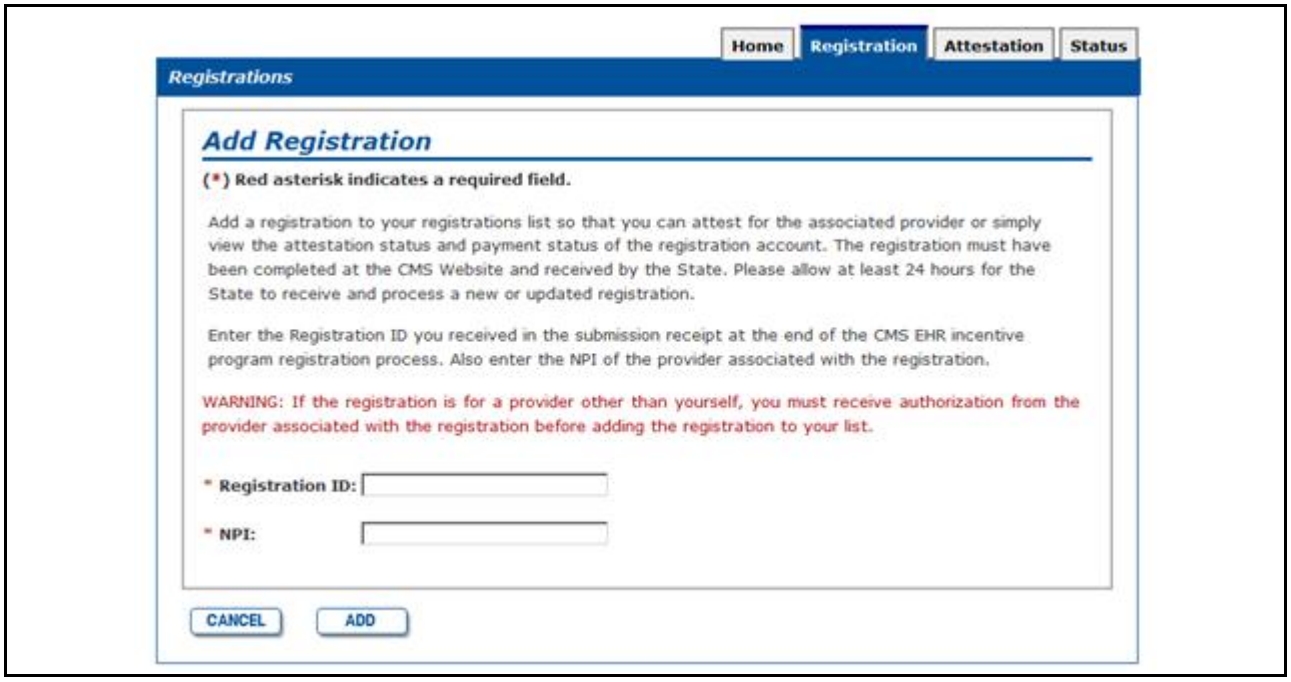

Home
Registration
Attestation
Status
Registrations
Add Registration
(*) Red asterisk indicates a required field.
Add a registration to your registrations list so that you can attest for the associated provider or simply view the attestation status and payment status of the registration account. The registration must have been completed at the CMS Website and received by the State. Please allow at least 24 hours for the State to receive and process a new or updated registration.
Enter the Registration ID you received in the submission receipt at the end of the CMS EHR incentive program registration process. Also enter the NPI of the provider associated with the registration.
WARNING: If the registration is for a provider other than yourself, you must receive authorization from the provider associated with the registration before adding the registration to your list.
* Registration ID:
* NPI:
CANCEL
ADD

Figure 22 - Registration Tab - Add Registration

1. Select the **Add Registration** button on the "Registration" Home Page.
2. Enter registration ID obtained from the CMS website.
3. Enter the EP's NPI.
4. Click the **Add** button.
    - ❑ The system validates that the registration ID is a valid ID assigned by CMS and that the correct NPI was entered.

- ❑ If valid, the registration ID and NPI are associated with the user ID. The "Registration Information" Page displays with the registration information that was entered. Refer to Figure 23.

5. The **Previous Page** button returns to the "Registration" Home Page.

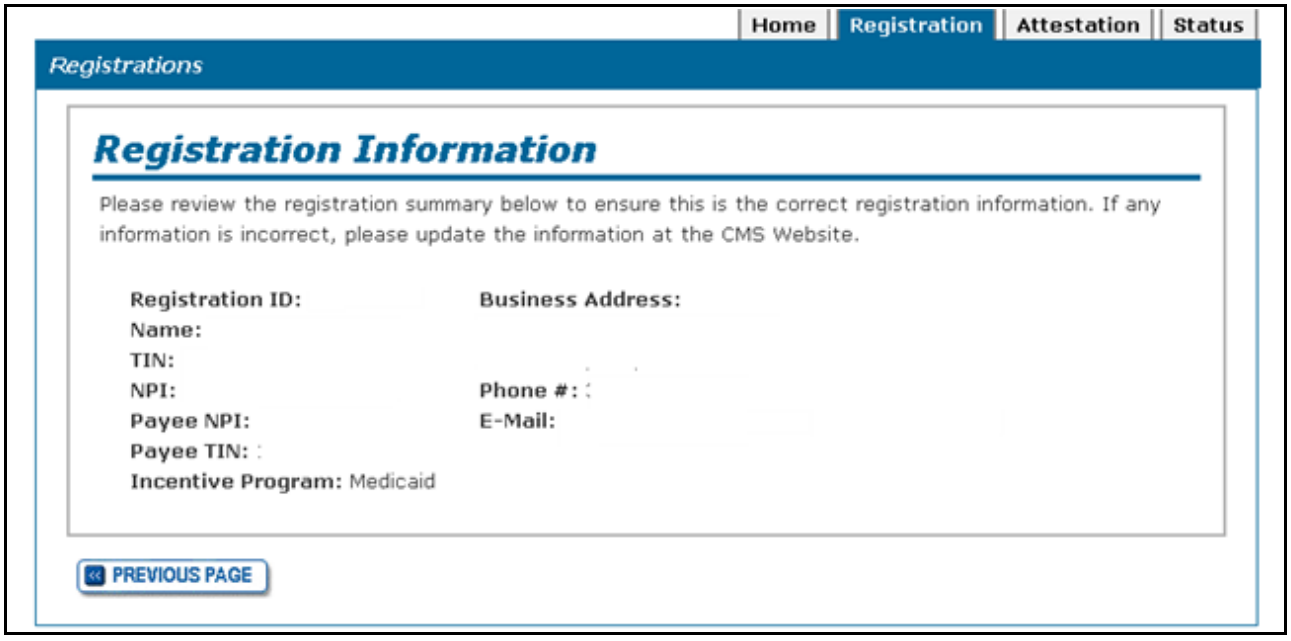


Figure 23 - Registration Tab - Registration Information Page

If invalid, an error message displays. The "Add Registration" page continues to display until the information is entered correctly or a navigation option is selected.

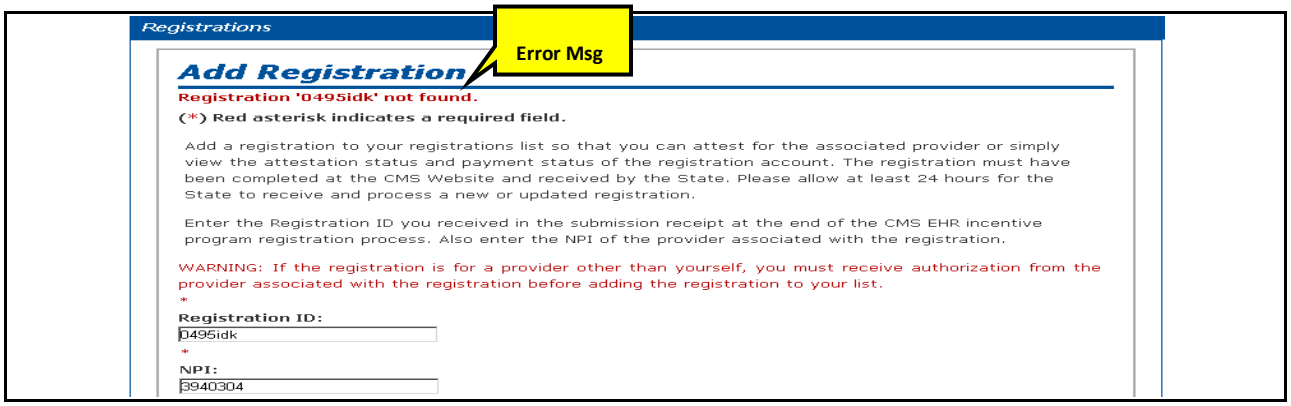

Registrations
Error Msg
Add Registration
Registration '0495idk' not found.
(*) Red asterisk indicates a required field.
Add a registration to your registrations list so that you can attest for the associated provider or simply view the attestation status and payment status of the registration account. The registration must have been completed at the CMS Website and received by the State. Please allow at least 24 hours for the State to receive and process a new or updated registration.
Enter the Registration ID you received in the submission receipt at the end of the CMS EHR incentive program registration process. Also enter the NPI of the provider associated with the registration.
WARNING: If the registration is for a provider other than yourself, you must receive authorization from the provider associated with the registration before adding the registration to your list.
*
Registration ID:
0495idk
*
NPI:
3940304

Figure 24 - Add Registration Error Message

The most common reasons why an error occurs:

- ❑ Information entered incorrectly. If necessary, access the CMS NLR website at ehrincentives.cms.gov to check the information or add a registration.

- The registration ID will not be found if 48 hours has not expired after registering on the CMS web site.

The **Cancel** button is an additional option that is available. Selecting the **Cancel** button does not add the registration ID and the "Registration" Home Page displays. No additional registration ID displays.

10.3.2 Registration – Select Option

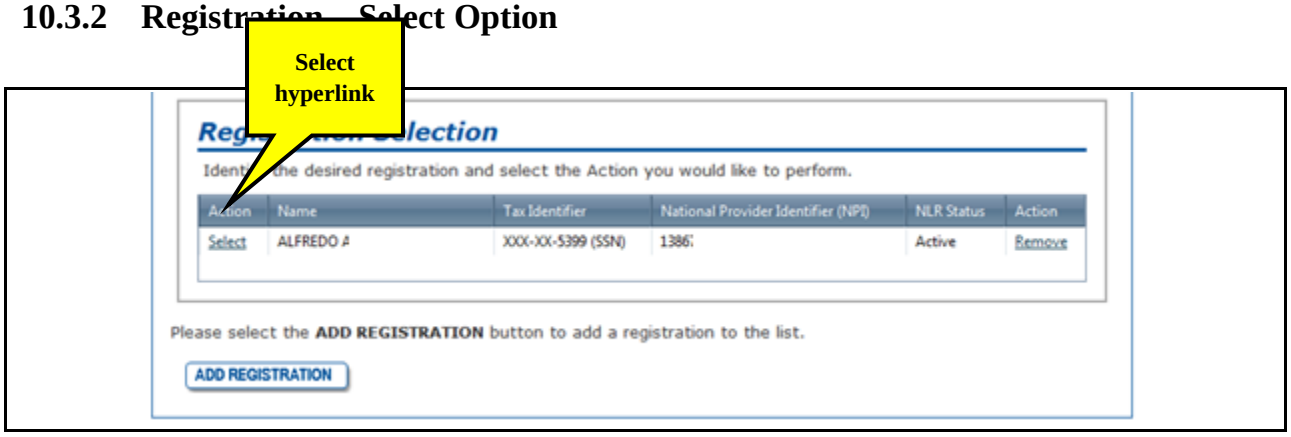


Figure 25 - Registration Tab - Registration Information Section

Select the **Select** hyperlink and the registration details displays for the registration ID selected. Refer to Figure 25.

10.3.3 Registration – Remove Option

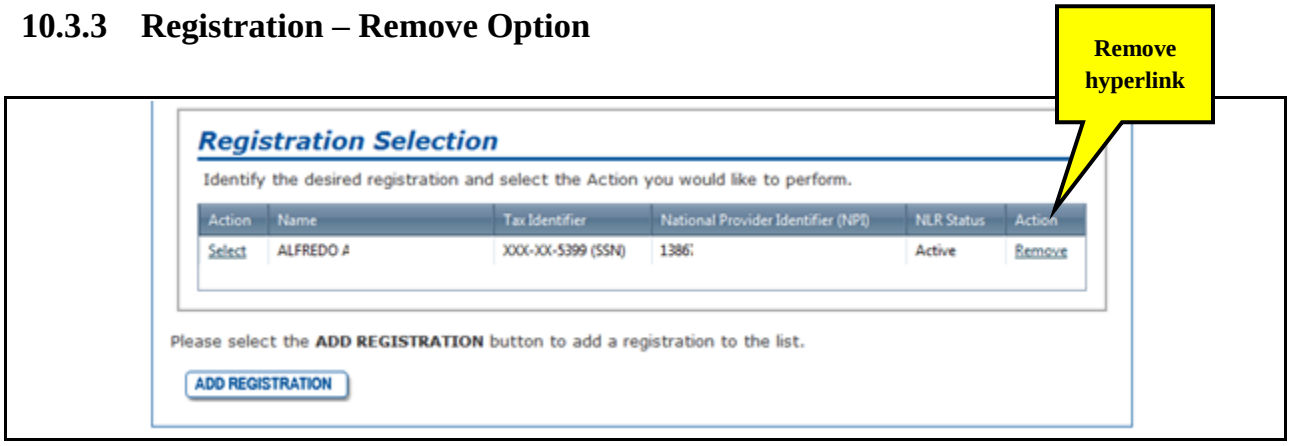


Figure 26 - Registration Tab - Remove Option

The **Remove** hyperlink next to a registration ID removes the registration ID from the user ID. The registration ID no longer displays in the registration and in the "Attestation" page. Refer to Figure 26.

The registration ID is still available for the user to reassign by executing the add registration steps as described in Section 10.3.1. The data that was entered is saved. NOTE: If someone else also registered the EP, the data that was entered by this user will display.

10.4 Attestation

The EP selects a registration and continues with populating the EP's attestation for that year. The solution will walk the EP through a series of Attestation screens that directly relate to the provider workbook the state has provided to assist the provider with completing attestation. The provider must complete these questions in order to proceed with submitting the attestation and potentially receiving payment.

The workbook provides the answers that will be entered in the appropriate screen so that the provider is prepared for answering all related questions prior to beginning the attestation process.

The "Attestation Workflow" consists of the following topics. The application will guide the user through the topics. A topic does not become active until the prerequisite topic is completed. Each topic will be addressed.

- Verify Registration Information
  - Verify the provider information is the correct provider.
  - Ability to indicate proxy usage
- Eligibility Screens
  - These screens walk the EP through the attestation-specific eligibility questions that he must complete to be validated as an EP for the Incentive Program
    - These screens include:
      - Questions on EP practice location
      - Questions on EP Medicaid patient volume
- Payment Screens
  - These screens walk the EP through the expected payment schedule and questions related
- Certified EHR Technology Screen
  - Adopt, Implement, Upgrade, or Meaningfully Use Certified EHR Technology Screen
    - This screen validates that the EP is indeed using a valid EHR solution
    - If meaningful use selected, entry of meaningful use objectives and clinical quality measures information is required
- Submit Attestation

To access the Attestation process, select the *Attestation* Tab.

Figure 27 - Attestation Tab

When selected, the "Attestation Instructions" Page displays. This page displays the registration IDs that are assigned to the user.

The user does not need to complete the attestation process in one sitting. Each screen in the attestation workflow has a **Save and Continue** button. This will save changes and allow the user to stop at any time without the loss of data that was entered on that page. The attestation process does not allow the user to skip forward to screens or jump past a screen without entering data. The user may edit answers until the attestation is submitted.

To start the attestation process:

1. Select the **Attest** option on the row showing the EP's registration information.

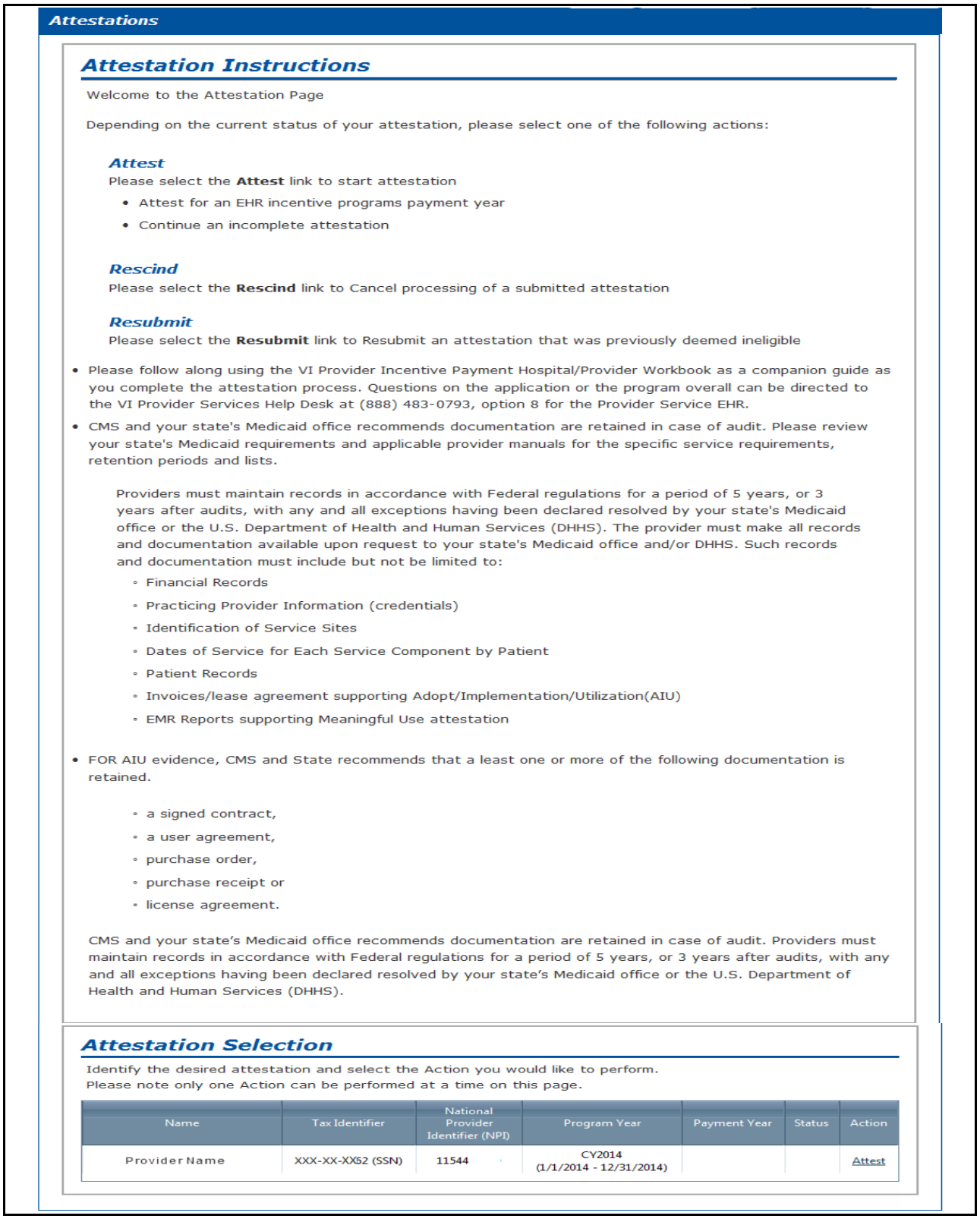

Attestations
Attestation Instructions
Welcome to the Attestation Page
Depending on the current status of your attestation, please select one of the following actions:
Attest
Please select the Attest link to start attestation
Attest for an EHR incentive programs payment year
Continue an incomplete attestation
Rescind
Please select the Rescind link to Cancel processing of a submitted attestation
Resubmit
Please select the Resubmit link to Resubmit an attestation that was previously deemed ineligible
Please follow along using the VI Provider Incentive Payment Hospital/Provider Workbook as a companion guide as you complete the attestation process. Questions on the application or the program overall can be directed to the VI Provider Services Help Desk at (888) 483-0793, option 8 for the Provider Service EHR.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Please review your state's Medicaid requirements and applicable provider manuals for the specific service requirements, retention periods and lists.
Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS). The provider must make all records and documentation available upon request to your state's Medicaid office and/or DHHS. Such records and documentation must include but not be limited to:
Financial Records
Practicing Provider Information (credentials)
Identification of Service Sites
Dates of Service for Each Service Component by Patient
Patient Records
Invoices/lease agreement supporting Adopt/Implementation/Utilization(AIU)
EMR Reports supporting Meaningful Use attestation
FOR AIU evidence, CMS and State recommends that a least one or more of the following documentation is retained.
a signed contract,
a user agreement,
purchase order,
purchase receipt or
license agreement.
CMS and your state's Medicaid office recommends documentation are retained in case of audit. Providers must maintain records in accordance with Federal regulations for a period of 5 years, or 3 years after audits, with any and all exceptions having been declared resolved by your state's Medicaid office or the U.S. Department of Health and Human Services (DHHS).
Attestation Selection
Identify the desired attestation and select the Action you would like to perform.
Please note only one Action can be performed at a time on this page.
Name
Tax Identifier
National Provider Identifier (NPI)
Program Year
Payment Year
Status
Action
Provider Name
XXX-XX-XX52 (SSN)
11544
CY2014 (1/1/2014 - 12/31/2014)
Attest

Figure 28 - Attestation Tab - Attestation Selection

2. Review the attestation status displayed on the "Attestation Topics" Page. If the EP is not listed, please select the *Status* tab. The *Status* tab will display attestations that are not actionable. Locate the EP in the list to see the error that prevented the EP from executing the attestation process.
3. The topics available on this page are as follows.

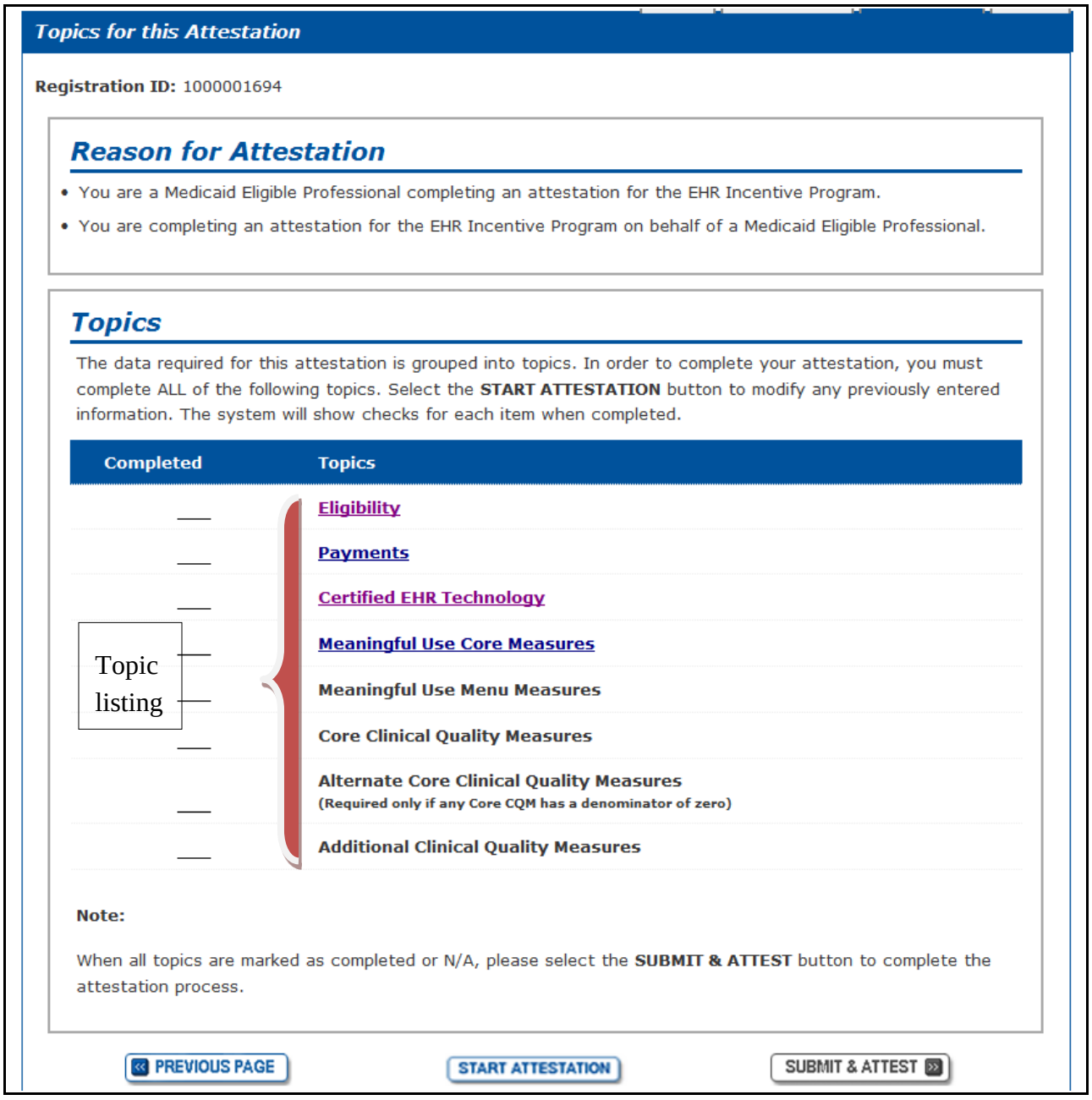

Topics for this Attestation
Registration ID: 1000001694
Reason for Attestation
• You are a Medicaid Eligible Professional completing an attestation for the EHR Incentive Program.
• You are completing an attestation for the EHR Incentive Program on behalf of a Medicaid Eligible Professional.
Topics
The data required for this attestation is grouped into topics. In order to complete your attestation, you must complete ALL of the following topics. Select the START ATTESTATION button to modify any previously entered information. The system will show checks for each item when completed.
Completed
Topics
Eligibility
Payments
Certified EHR Technology
Meaningful Use Core Measures
Meaningful Use Menu Measures
Core Clinical Quality Measures
Alternate Core Clinical Quality Measures
(Required only if any Core CQM has a denominator of zero)
Additional Clinical Quality Measures
Topic listing
Note:
When all topics are marked as completed or N/A, please select the SUBMIT & ATTEST button to complete the attestation process.
PREVIOUS PAGE
START ATTESTATION
SUBMIT & ATTEST

Figure 29 - Attestation Tab - Attestation Topic Listing

- The topic listing identifies the completed topic by placing an indicator next to the topic; a topic is completed when the required answers are entered and saved.

- Topics become available as prerequisite topics are completed.

Select the **Start Attestation** button to start the attestation process or to continue to add and modify data already entered.

Select the **Submit & Attest** button when satisfied with the data that is entered. This submits the responses to determine eligibility for payment processing. This submits the data to the State for review.

- The **Submit & Attest** button is disabled on the initial selection of a registration ID.

The **Submit & Attest** button is disabled if the eligibility check was set to "Ineligible".

Select the **Previous Page** button to display the "Attestation Selection" Page.

On selection of the **Start Attestation** button, the "Registration Information" Page will display.

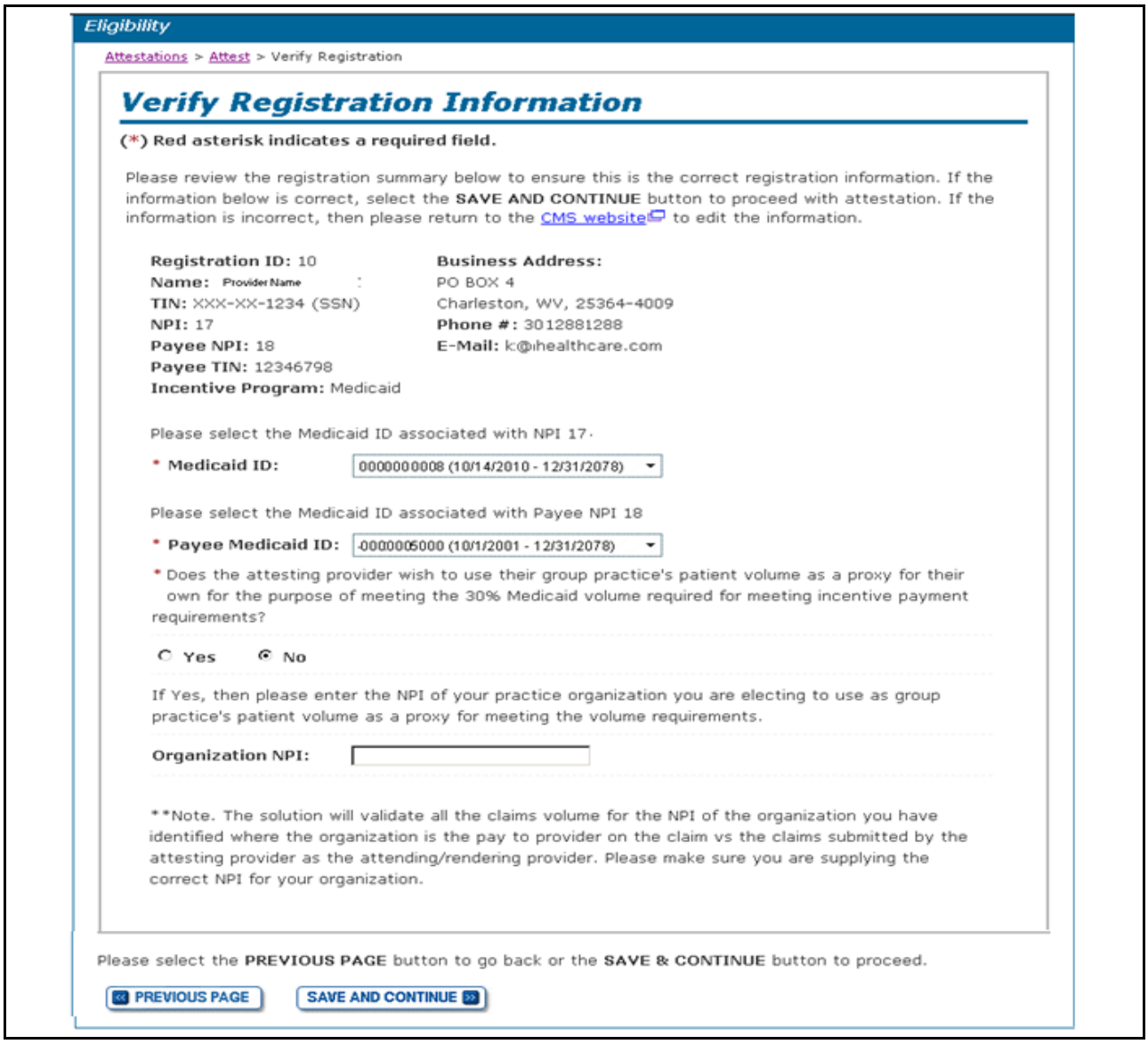

Eligibility
Attestations > Attest > Verify Registration
Verify Registration Information
(*) Red asterisk indicates a required field.
Please review the registration summary below to ensure this is the correct registration information. If the information below is correct, select the SAVE AND CONTINUE button to proceed with attestation. If the information is incorrect, then please return to the CMS website to edit the information.
Registration ID: 10
Name: Provider Name
TIN: XXX-XX-1234 (SSN)
NPI: 17
Payee NPI: 18
Payee TIN: 12346798
Incentive Program: Medicaid
Business Address:
PO BOX 4
Charleston, WV, 25364-4009
Phone #: 3012881288
E-Mail: k@ihealthcare.com
Please select the Medicaid ID associated with NPI 17.
* Medicaid ID: 0000000008 (10/14/2010 - 12/31/2078)
Please select the Medicaid ID associated with Payee NPI 18
* Payee Medicaid ID: 0000005000 (10/1/2001 - 12/31/2078)
* Does the attesting provider wish to use their group practice's patient volume as a proxy for their own for the purpose of meeting the 30% Medicaid volume required for meeting incentive payment requirements?
Yes
No
If Yes, then please enter the NPI of your practice organization you are electing to use as group practice's patient volume as a proxy for meeting the volume requirements.
Organization NPI:
**Note. The solution will validate all the claims volume for the NPI of the organization you have identified where the organization is the pay to provider on the claim vs the claims submitted by the attesting provider as the attending/rendering provider. Please make sure you are supplying the correct NPI for your organization.
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 30 - Attestation Tab - Verify Registration

- Select Medicaid ID
  - Purpose: if an EP's NPI matches on more than one USVI Medicaid provider ID, the EP may select which Medicaid provider ID they wish to use for his attestation or for receiving payments.
  - Displays the NLR submitted NPI number's matching Medicaid IDs for the payee that was registered for along with their active Medicaid ID enrollment dates**.**
  - Please note that the EP doesn't have to be an actively enrolled in Medicaid to be paid. The EP needs to have a "pay to" affiliation active with USVI MMIS at the time of the attestation period submitted for volume and meaningful use.

- Dropdown box displays the Medicaid IDs. Select drop down box option to display the Medicaid IDs that were found. Highlight the desired ID and click mouse to select.

- Select Payee Medicaid ID
  - Select the Medicaid provider ID that will be used for payment. An EP may have one-to- many Medicaid provider IDs on file matching to the provider's single NPI on record. The designated NPI for payee should be matched to the corresponding Medicaid provider ID that the provider wished to have the payment sent to ensure the appropriate match to the USVI Medicaid payee affiliation records.
  - Dropdown box displays the Medicaid provider IDs. Select drop down box to display the Medicaid providers IDs that were found to be associated with the payee NPI.

- Select election to use group practice patient volume values.

Please enter the election to use the group practice's patient volume as a proxy for the individual EP's patient volume. Please remember that the following criteria must be met to use this proxy value:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP (for example, if an EP only sees Medicare, commercial, or self-pay patients, this is not an appropriate calculation);
- There is an auditable data source to support the clinic's or group practice's patient volume determination;
- So long as the practice and EPs decide to use one methodology in each year (in other words, clinics could not have some of the EPs using their individual patient volume for patients seen at the clinic, while others use the clinic-level data). The clinic or practice must use the entire practice's patient volume and not limit it in any way. EPs may attest to patient volume under the individual calculation or the group/clinic proxy in any participation year. Furthermore, if the EP works both in the clinic and outside the clinic (or with and outside a group practice), the clinic/practice level determination includes only those encounters associated with the clinic/practice.

1. Select Yes or No
2. If Yes is selected, enter organization's NPI.
3. Select the **Save and Continue** button.

10.4.1 Attestation Eligibility

The purpose of the "Attestation Eligibility" section is to determine if the practice setting and Medicaid patient volume thresholds are met. In order to be eligible for the Medicaid EHR

Incentive Program, eligible professionals (EPs) must meet a Medicaid patient volume threshold. For most professionals, this means a 30% eligible patient volume based on total patient encounters. For most EPs, eligible patient volume only includes Medicaid encounters; however, EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) have different criteria; as described in the details below.

Pediatricians have special rules and are allowed to participate with a reduced eligible patient volume threshold (20% instead of 30%). If a pediatrician's Medicaid patient volume is greater than 20% but less than 30%, he will receive a 2/3 Medicaid EHR Incentive Program payment. Pediatricians who achieve 30% eligible patient volume are eligible to receive the full Medicaid EHR Incentive Program payment amount.

10.4.1.1 Encounter Calculation

For purposes of calculating EP eligible patient volume, a Medicaid encounter as defined by the USVI Medicaid EHR Incentive Program is "An encounter should be a reflected in the count as one or more claims for the same patient for the same rendering physician for the same date of service (DOS). This should be a count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid paid encounters including inpatient, outpatient, and emergency room services. The USVI Medicaid EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS encounter count within the numerator." In other words, Eligible Professionals should count the following as 1 patient encounter: 1 to many claims for the same patient where the claim has the same DOS and the same rendering/attending provider. All claims related to the actual "encounter" with the patient for the same date, same provider.

10.4.1.2 Eligibility Screen 1 – Service Setting

In addition to the overall Medicaid patient volume thresholds, only EPs that are not hospital-based are eligible to receive Medicaid EHR Incentive Program payments. For the purposes of the Medicaid EHR Incentive Program, if the EP is performing 90% or more of his encounters in an inpatient or emergency room setting, the solution will PEND the attestation for further review. The following section aids in determining whether a provider meets the threshold for being hospital-based.

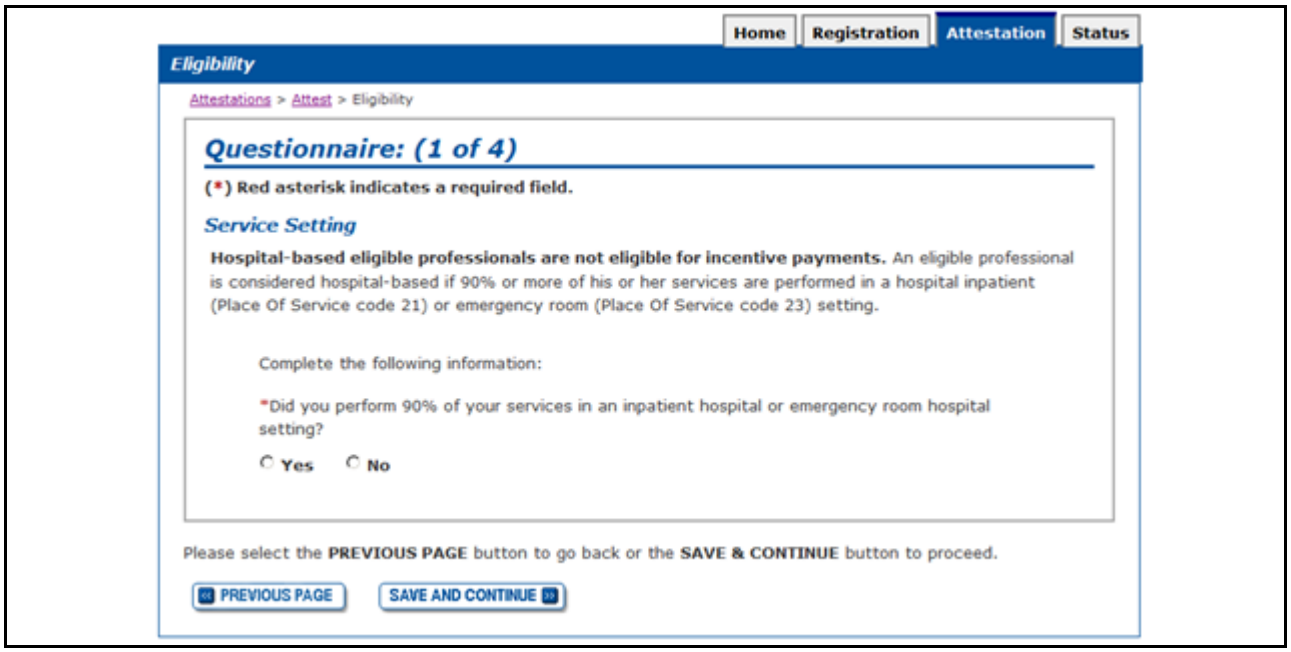

Home
Registration
Attestation
Status
Eligibility
Attestations > Attest > Eligibility
Questionnaire: (1 of 4)
(*) Red asterisk indicates a required field.
Service Setting
Hospital-based eligible professionals are not eligible for incentive payments. An eligible professional is considered hospital-based if 90% or more of his or her services are performed in a hospital inpatient (Place Of Service code 21) or emergency room (Place Of Service code 23) setting.
Complete the following information:
*Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 31 - Attestation Tab - Service Setting

1. Select YES if hospital-based, then select the **Save and Continue** button.

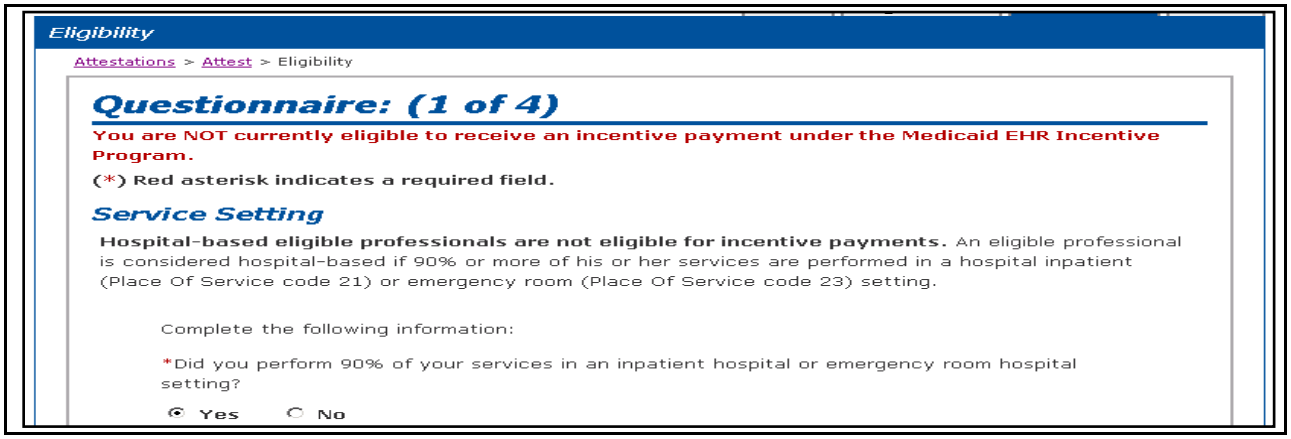

Eligibility
Attestations > Attest > Eligibility
Questionnaire: (1 of 4)
You are NOT currently eligible to receive an incentive payment under the Medicaid EHR Incentive Program.
(*) Red asterisk indicates a required field.
Service Setting
Hospital-based eligible professionals are not eligible for incentive payments. An eligible professional is considered hospital-based if 90% or more of his or her services are performed in a hospital inpatient (Place Of Service code 21) or emergency room (Place Of Service code 23) setting.
Complete the following information:
*Did you perform 90% of your services in an inpatient hospital or emergency room hospital setting?
Yes
No

Figure 32 - Attestation Tab - Service Setting Error

- Hospital-based providers are not eligible to receive Medicaid EHR Incentive Program payments.

- The application will display an error message, "You are NOT currently eligible to receive an incentive payment under the Medicaid EHR Incentive Program. " The attestation process is halted and the user will not be allowed to continue entering in information. The eligibility status is set to "Ineligible".

2. Select NO if the provider is NOT hospital-based and select the **Save and Continue** button.

    - The application will continue to the Eligibility Screen 2 – Volume Check question.

3. Select the **Previous Page** button to display the "Verify Registration" page.

    - Regardless of the answer and after attestation submission and finalization (48 hours after submittal) the system will validate the EP's attestation that they practice predominately outside a hospital by checking the place of service for the attesting EP's Medicaid fee-for-service for the period specified within the system to validate Medicaid volume. If the EP is performing more than 90% of his encounters in an inpatient or emergency room setting, the solution will PEND the attestation for further review. The EP may then contact the Medicaid Provider Services Helpdesk to review their attestation and work through the issues causing the "PEND" status. The user will not be able to continue entering attestation data.

10.4.1.3 Eligibility Screen 2 – Volume Check

The purpose of this screen is to determine if the EP's or group practice's Medicaid patient volume meets the Medicaid patient volume required to be eligible for the Medicaid EHR Incentive Program.

In order to be eligible for the Medicaid EHR Incentive Program, the following conditions must be met:

- Eligible professionals (EPs) must meet eligible patient volume thresholds. For most EPs, this means a 30% Medicaid patient volume based on total patient encounters for a selected 90-day patient volume period.
- If the EP is registered as a pediatrician with a Medicaid patient volume greater than 20% but less than a 30% eligible patient volume, he is eligible for a 2/3 payment for the given Medicaid EHR Incentive Program payment year.
- Pediatricians with a Medicaid patient volume greater than 30% are eligible to receive the full incentive amount they qualify for.

EPs that "practice predominantly" at a Federally Qualified Health Center (FQHC) or a Rural Health Clinic (RHC) and do not meet their applicable Medicaid patient volume threshold will be able to use an alternate patient volume methodology, which is discussed in sections 10.4.1.3.2 and 10.4.1.3.3.

10.4.1.3.1 Out of State Encounters

If the EP has significant Medicaid encounters from another Medicaid agency, then this EP may add the encounters from the other state or states to his or her in-state encounter count to meet the application Medicaid patient volume threshold. Entering out-of-state patient volume is optional at the discretion of the EP. The "Volume" page provides functionality to add and maintain out-of-state (OOS) volume counts. When an attestation with OOS entries is submitted, the attestation will be placed in a Pend status once the in-state Medicaid patient encounter counts are validated. USVI Medicaid department will review the attestation to ensure the appropriate documentation was provided and also to review the documentation to determine if the attestation will be accepted or rejected. The EP must obtain the encounter counts from the other status(s) MMIS and be prepared to submit the following documentation.

- Certification on official letterhead from the state Medicaid agency or agencies declaring the numbers obtained were derived from the State's MMIS and are accurate.
- Report generated by the other state Medicaid agency or agencies with the total Fee-for-Service count and reporting period.

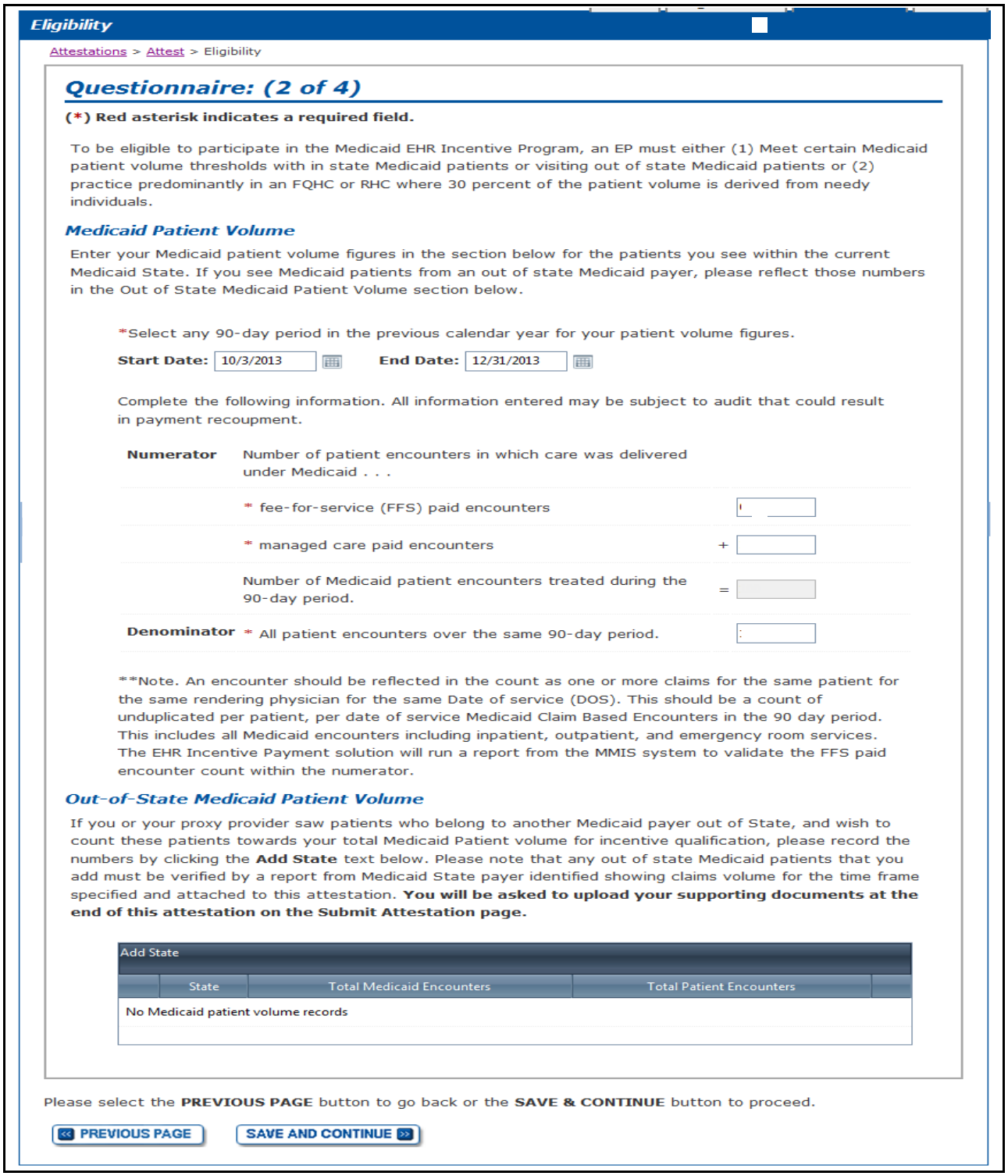

Eligibility
Attestations > Attest > Eligibility
Questionnaire: (2 of 4)
(*) Red asterisk indicates a required field.
To be eligible to participate in the Medicaid EHR Incentive Program, an EP must either (1) Meet certain Medicaid patient volume thresholds with in state Medicaid patients or visiting out of state Medicaid patients or (2) practice predominantly in an FQHC or RHC where 30 percent of the patient volume is derived from needy individuals.
Medicaid Patient Volume
Enter your Medicaid patient volume figures in the section below for the patients you see within the current Medicaid State. If you see Medicaid patients from an out of state Medicaid payer, please reflect those numbers in the Out of State Medicaid Patient Volume section below.
*Select any 90-day period in the previous calendar year for your patient volume figures.
Start Date: 10/3/2013
End Date: 12/31/2013
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator
Number of patient encounters in which care was delivered under Medicaid . . .
* fee-for-service (FFS) paid encounters
* managed care paid encounters
+
Number of Medicaid patient encounters treated during the 90-day period.
=
Denominator
* All patient encounters over the same 90-day period.
**Note. An encounter should be reflected in the count as one or more claims for the same patient for the same rendering physician for the same Date of service (DOS). This should be a count of unduplicated per patient, per date of service Medicaid Claim Based Encounters in the 90 day period. This includes all Medicaid encounters including inpatient, outpatient, and emergency room services. The EHR Incentive Payment solution will run a report from the MMIS system to validate the FFS paid encounter count within the numerator.
Out-of-State Medicaid Patient Volume
If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the Add State text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.
Add State
State
Total Medicaid Encounters
Total Patient Encounters
No Medicaid patient volume records
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 33 - Attestation Tab - Medicaid Patient Volume

1. Enter the start date or end date of the EP's patient volume period by typing in the date or selecting the calendar icon to the right of either box. The application will then automatically calculate the appropriate 90 day window for the EP's chosen volume measurement period.
2. Enter the number of Medicaid (Title XIX only) fee-for-service and Medicaid managed care patient encounters for EP or proxy entity being used by the EP for the 90 day patient volume measurement period calculated at the top of the screen. The sum of these two numbers will be the numerator for the patient volume calculation.
    - ❑ Do not add commas. The application will insert commas, as needed, after entry.
3. Enter the total number of patient encounters for the EP or proxy entity being used by the EP for the 90 day patient volume measurement period calculated at the top of the screen. This amount will be the denominator for the EP's patient volume calculation.
    - ❑ Do not add commas. The application will insert commas, as needed, after entry.
4. Out of State Encounters (Optional)

    The screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Each option's instructions are bulleted sections following this screen shot.

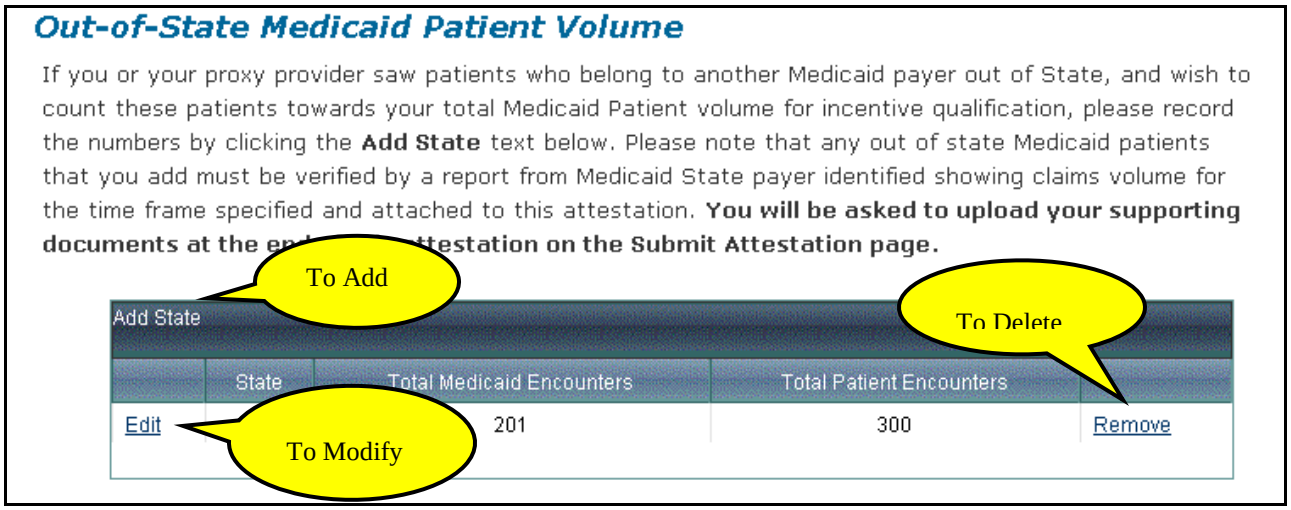

Out-of-State Medicaid Patient Volume
If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the Add State text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. You will be asked to upload your supporting documents at the end of the attestation on the Submit Attestation page.
To Add
Add State
To Delete
State
Total Medicaid Encounters
Total Patient Encounters
Edit
201
300
Remove
To Modify

Figure 34 - Attestation Tab - Out-of-State Medicaid Patient Volume

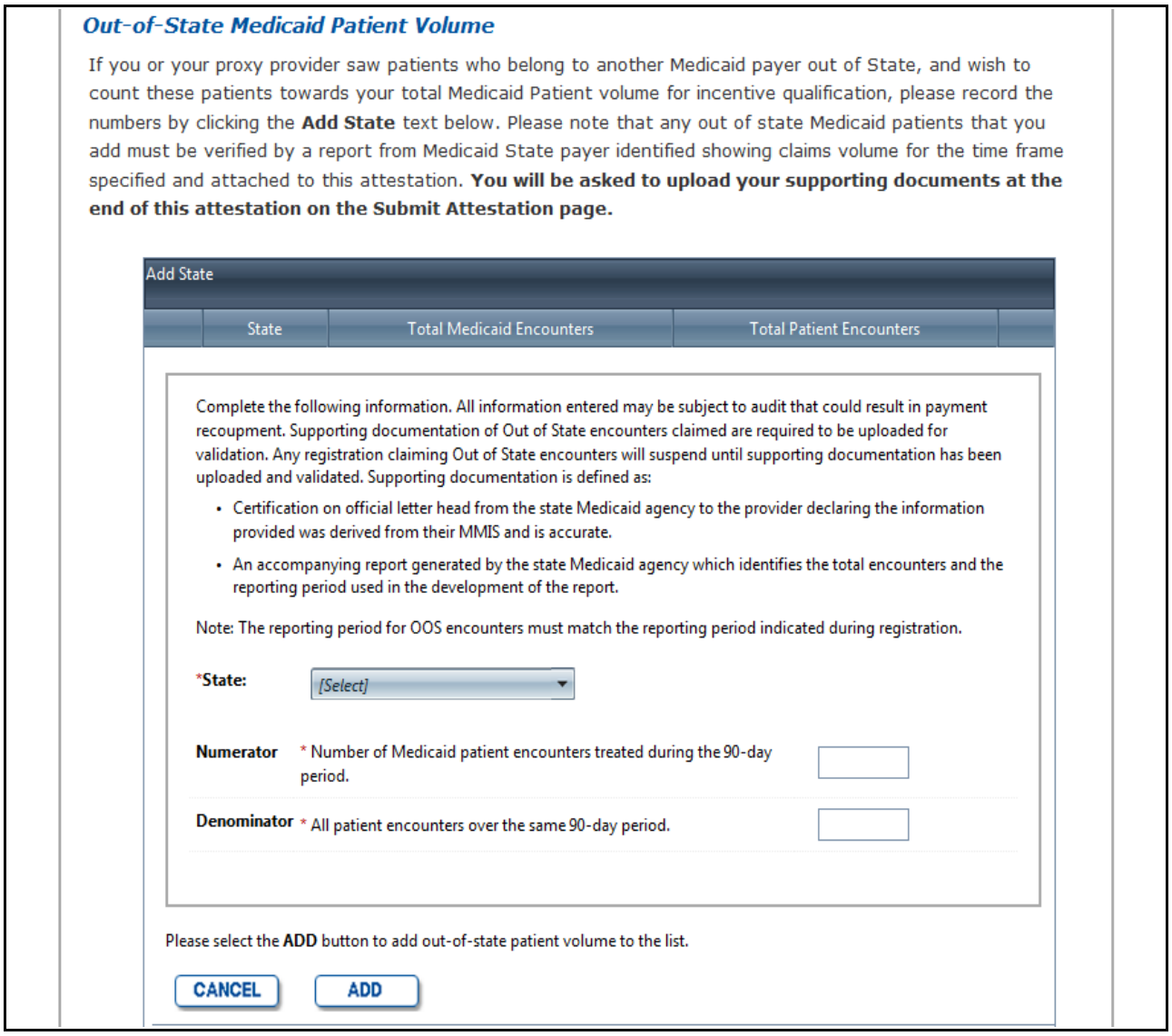

Out-of-State Medicaid Patient Volume
If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the Add State text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.
Add State
State
Total Medicaid Encounters
Total Patient Encounters
Complete the following information. All information entered may be subject to audit that could result in payment recoupment. Supporting documentation of Out of State encounters claimed are required to be uploaded for validation. Any registration claiming Out of State encounters will suspend until supporting documentation has been uploaded and validated. Supporting documentation is defined as:
Certification on official letter head from the state Medicaid agency to the provider declaring the information provided was derived from their MMIS and is accurate.
An accompanying report generated by the state Medicaid agency which identifies the total encounters and the reporting period used in the development of the report.
Note: The reporting period for OOS encounters must match the reporting period indicated during registration.
*State:
[Select]
Numerator
* Number of Medicaid patient encounters treated during the 90-day period.
Denominator
* All patient encounters over the same 90-day period.
Please select the ADD button to add out-of-state patient volume to the list.
CANCEL
ADD

Figure 35 – Attestation Tab - Out-of-State Entry - Add/Edit Screen

- To Add Out of State entry:
    1. Select **Add State** to display the screen above.
    2. Select a State from the drop down list.
    3. Enter encounters counts for the selected state
    4. Enter in denominator, which is the total patient encounters for the selected state
    5. Select **Add** button

    To enter patient encounter information for additional states, repeat Steps 1- 5.

- To modify an out-of-state entry:
    1. Select **Edit**

2. The screen will display the selected out-of-state entry
3. Select **Update** button

- To delete an out-of-state entry
    1. Select **Remove**
    2. Verify the entry being deleted by responding to the question presented. If the EP does not meet an applicable Medicaid patient volume threshold, then "Volume Screen 3" will display.

If the eligible EP meets or exceeds the Medicaid patient volume required to receive a USVI Medicaid EHR Incentive Program payment, the application will display the "Payment Calculation" page. Once the EP has completed and submitted his attestation for process, his Medicaid patient volume information will be verified against the fee-for-service claims in USVI MMIS. All information entered into the application is subject to post-payment audit.

If the EP does not meet the required Medicaid patient threshold after entering in all of his patient volume information, additional screens will appear presenting a possible alternative patient volume calculation.

10.4.1.3.2 Volume Screen 3 – If initial Eligibility volume is not met

The purpose of this screen is to provide an EP practicing predominantly in an FQHC an alternative "Needy Individual" patient volume measurement methodology to establish Medicaid EHR Incentive Program eligibility.

> The EP must have performed 50% of more of their overall patient encounters over a six month period in the calendar year prior to the attestation year in an FQHC or RHC in order to be eligible to use this alternative, "Needy Individual" patient volume calculation. "Volume Screen 3" (shown below in Figure 36) asks the EP to provide the necessary information to determine if they meet these criteria.

Home
Registration
Attestation
Status
Eligibility
Attestations > Attest > Eligibility
Questionnaire: (3 of 4)
(*) Red asterisk indicates a required field.
FQHC/RHC Patient Volume
Although you do not meet the required Medicaid patient volume threshold, you may be eligible for an incentive payment if you practice predominantly in a federally-qualified health center (FQHC) or a rural health clinic (RHC).
*Select any 6-month period in the previous calendar year for your patient volume figures.
Start Date: 7/1/2010
End Date: 12/31/2010
Complete the following information:
Numerator Number of patient encounters in which the clinical location occurred at an FQHC or RHC during the 6-month period.
Denominator All patient encounters over the same 6-month period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 36 - Attestation Tab - FQHC/RHC Patient Volume

1. Enter the start date or end date by typing in the date or selecting the calendar icon to the right of either box. The system will automatically calculate the six month patient volume calculation period.
2. Enter the number of patient encounters performed by the EP at an FQHC or RHC in the selected six month period. A patient encounter is defined as a unique provider, patient, date-of-service, and place-of-service combination. This count must belong to the EP alone; no proxy entity measure (such as for a group practice or clinic) may be utilized when counting FQHC patient encounters. This will be the numerator used to determine if the EP practices predominantly in an FQHC.
   - ❑ Do not add commas. The application will insert commas, as needed, after entry.
3. Enter the total number of patient encounters performed by the EP (regardless of setting) over the selected six month period. This count must belong to the EP alone; no proxy entity measure (such as a group practice or clinic) may be utilized when counting the total number of encounters. This will be the denominator used to determine if the EP practiced predominantly in an FQHC.
   - ❑ Do not add commas. The application will insert commas, as needed, after entry.
4. Select **Save and Continue**.

The application will validate if all fields have data entered:

- If any field does not contain an entry, an error message will display. Please enter the appropriate data.

If all fields contain responses, the next action depends on the data entered.

- If the EP meets the 50% patient volume threshold needed to be considered to be "practicing predominantly" in an FQHC or RHC, the EP will proceed to "Volume Screen 4".
- If the EP does not meet the 50% patient volume threshold needed to be considered to be "practicing predominantly" in an FQHC or RHC, then the EP will not be allowed to continue their attestation. If the EP has questions or needs assistance, they should call the USVI Medicaid Provider Services Help Desk at 855-248-7536 option 2 to speak with a USVI Medicaid EHR Incentive Program representative.

10.4.1.3.3 Volume Screen 4 – Needy Patient Volume

EPs that practice predominantly in an FQHC or RHC are allowed to use a more inclusive "Needy Individual" patient volume measure to establish their eligibility for the USVI Medicaid EHR Incentive Program. An EP "practices predominantly" at an FQHC or an RHC when the clinical location for over 50% of his/her total patient encounters over a period of 6 months in the calendar year prior to the attestation year occur at an FQHC or RHC. EPs who practice in an FQHC or RHC but do not meet the "predominantly practicing" threshold can still qualify for a Medicaid EHR Incentive Program payment using Medicaid (Title XIX only) patient volume calculations and thresholds discussed earlier in this section, but are not eligible to use the "Needy Individual" patient volume measure described in this section.

Needy Individual Encounters Defined

The USVI Medicaid EHR Incentive Program defines a qualified patient encounter as a unique provider, patient, date-of-service, and place-of-service combination, including inpatient, outpatient, and emergency room services. "Needy Individual" patient encounters include services rendered to an individual on any one day where any of the following are met:

- Medicaid (Title XIX) (or a Medicaid demonstration project approved under section 1115 of the Social Security Act) paid for part or all of the service;
- Medicaid (or a Medicaid demonstration project approved under section 1115 of the Social Security Act) paid all or part of the individual's premiums, co-payments, or cost-sharing;
- The services were furnished at no cost;
- The services were paid for at a reduced cost based on a sliding scale determined by the individual's ability to pay.

The USVI Medicaid EHR Incentive Program Attestation Application will run a report from the USVI MMIS to validate the Medicaid fee-for-service counts included in the numerator of the "Needy Individual" patient volume calculation. At the EP's option, out-of-state patient encounters meeting the four "Needy Individual" criteria above may be used to establish USVI Medicaid EHR Incentive Program eligibility. All information entered into the USVI Medicaid EHR Incentive Program Attestation Application is subject to post-payment audit that could result in payment recoupment.

An example of the screen used to enter "Needy Individual" patient volume information is shown below in Figure 37, followed by instructions on how to complete the screen.

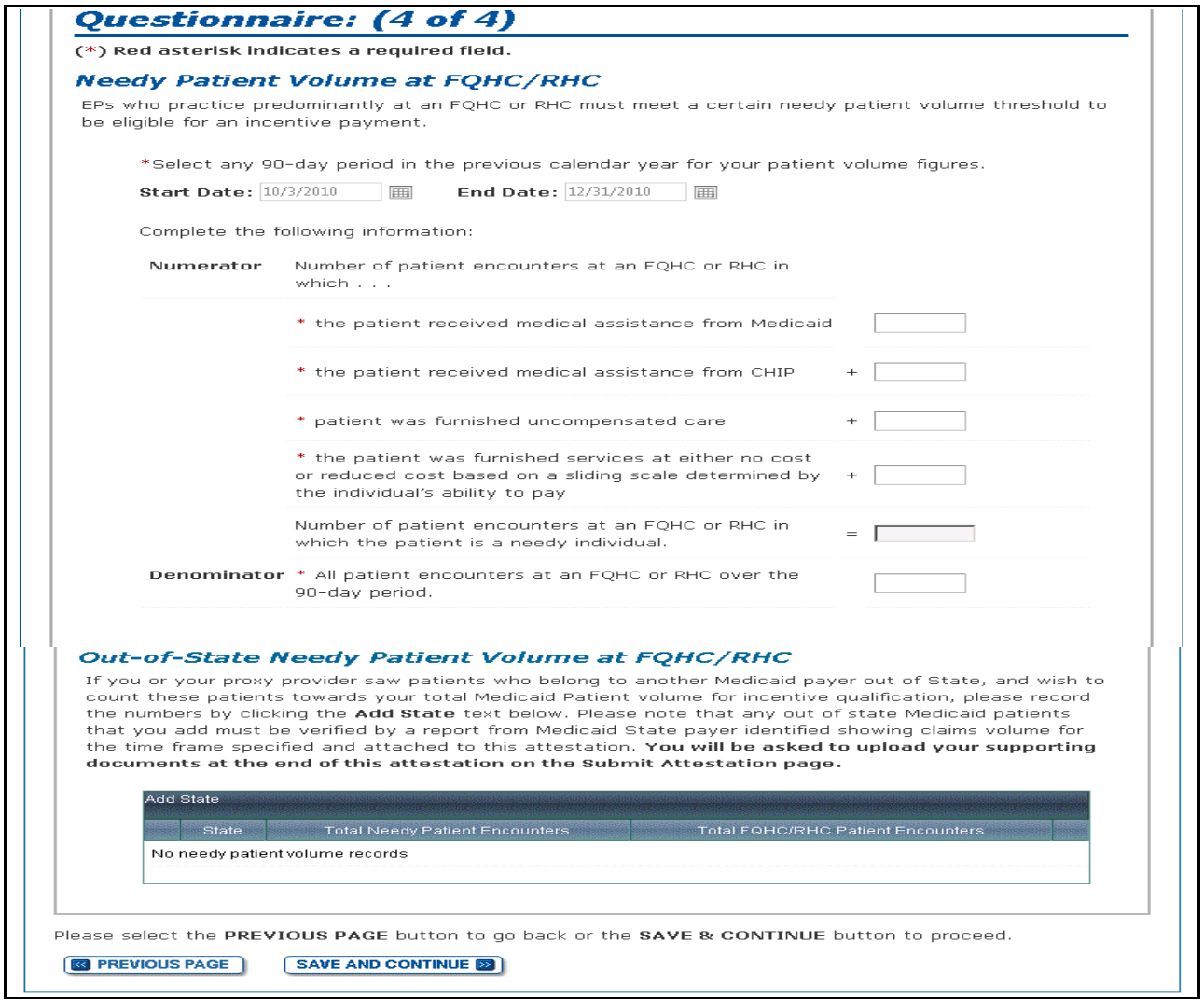

Questionnaire: (4 of 4)
(*) Red asterisk indicates a required field.
Needy Patient Volume at FQHC/RHC
EPs who practice predominantly at an FQHC or RHC must meet a certain needy patient volume threshold to be eligible for an incentive payment.
*Select any 90-day period in the previous calendar year for your patient volume figures.
Start Date: 10/3/2010
End Date: 12/31/2010
Complete the following information:
Numerator
Number of patient encounters at an FQHC or RHC in which . . .
* the patient received medical assistance from Medicaid
* the patient received medical assistance from CHIP +
* patient was furnished uncompensated care +
* the patient was furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay +
Number of patient encounters at an FQHC or RHC in which the patient is a needy individual. =
Denominator
* All patient encounters at an FQHC or RHC over the 90-day period.
Out-of-State Needy Patient Volume at FQHC/RHC
If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the Add State text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.
Add State
State
Total Needy Patient Encounters
Total FQHC/RHC Patient Encounters
No needy patient volume records
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 37 - Attestation Tab - Needy Patient Volume at FQHC/RHC

1. Enter the start date or end date of the EP's patient volume attestation period by typing in the date or selecting the calendar icon to the right of either box. The application will then

automatically calculate the appropriate 90 day window for the EP's chosen patient volume period.

2. For the selected 90-day patient volume period, enter the number of patient encounters that meet the criteria for each question.

    2. Enter the number of encounters performed at an FQHC or RHC that received Medicaid reimbursement. This amount includes the unique provider, patient, date of service, and place of service combinations where Medicaid (Title XIX, fee-for-service) or Medicaid demonstration project under section 1115 of the Social Security Act paid for part or all of the service or paid all or part of the premiums, co-payments, and/or cost sharing.

        - ❑ Do not add commas. The application will insert commas, as needed, after entry.

    3. Enter the number of encounters performed at an FQHC or RHC that received CHIP reimbursement.

        - ❑ Do not add commas. The application will insert commas, as needed, after entry.
        - ❑ CHIP is a required field and CHIP programs are not available in USVI. Enter 0.

    4. Enter the number of FQHC or RHC patients provided uncompensated care at an FQHC or RHC. This amount includes the unique provider, patient, date-of-service, and place-of-service combinations for which the EP received no compensation.

        - ❑ Do not add commas. The application will insert commas, as needed, after entry.

    5. Enter the number of FQHC or RHC patient encounters provided at either no cost or reduced cost based on the sliding scale determined by the individual's ability to pay. This amount includes the unique provider, patient, date-of-service, and place of service combinations that meet the required criteria.

        - ❑ Do not add commas. System will format with commas after entry.

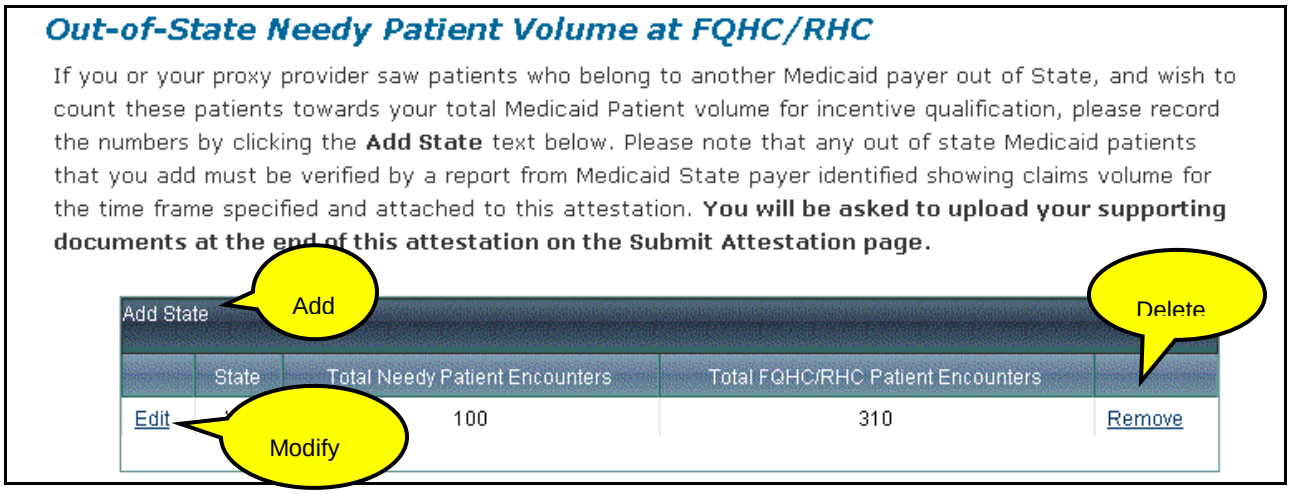
    6. The application will generate the total number of "Needy Individual" encounters using the information entered in steps 1-5

    7. Enter the denominator. This amount is the total number of patient encounters rendered by the EP for the selected 90 day period based on reports generated from an auditable source, such as practice management or EHR systems.

        - ❑ Do not add commas. System will format with commas after entry.

Out-of-State Entry (Optional)

The screen allows for entry of out-of-state entries. The following is a sample of a screen to display the different options available to the user. Each option's instructions are bulleted sections following this screen shot.


Out-of-State Needy Patient Volume at FQHC/RHC
If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the Add State text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.
Add State
Add
Delete
State
Total Needy Patient Encounters
Total FQHC/RHC Patient Encounters
Edit
100
310
Remove
Modify

- To Add

1. Select **Add State** to display the following screen.

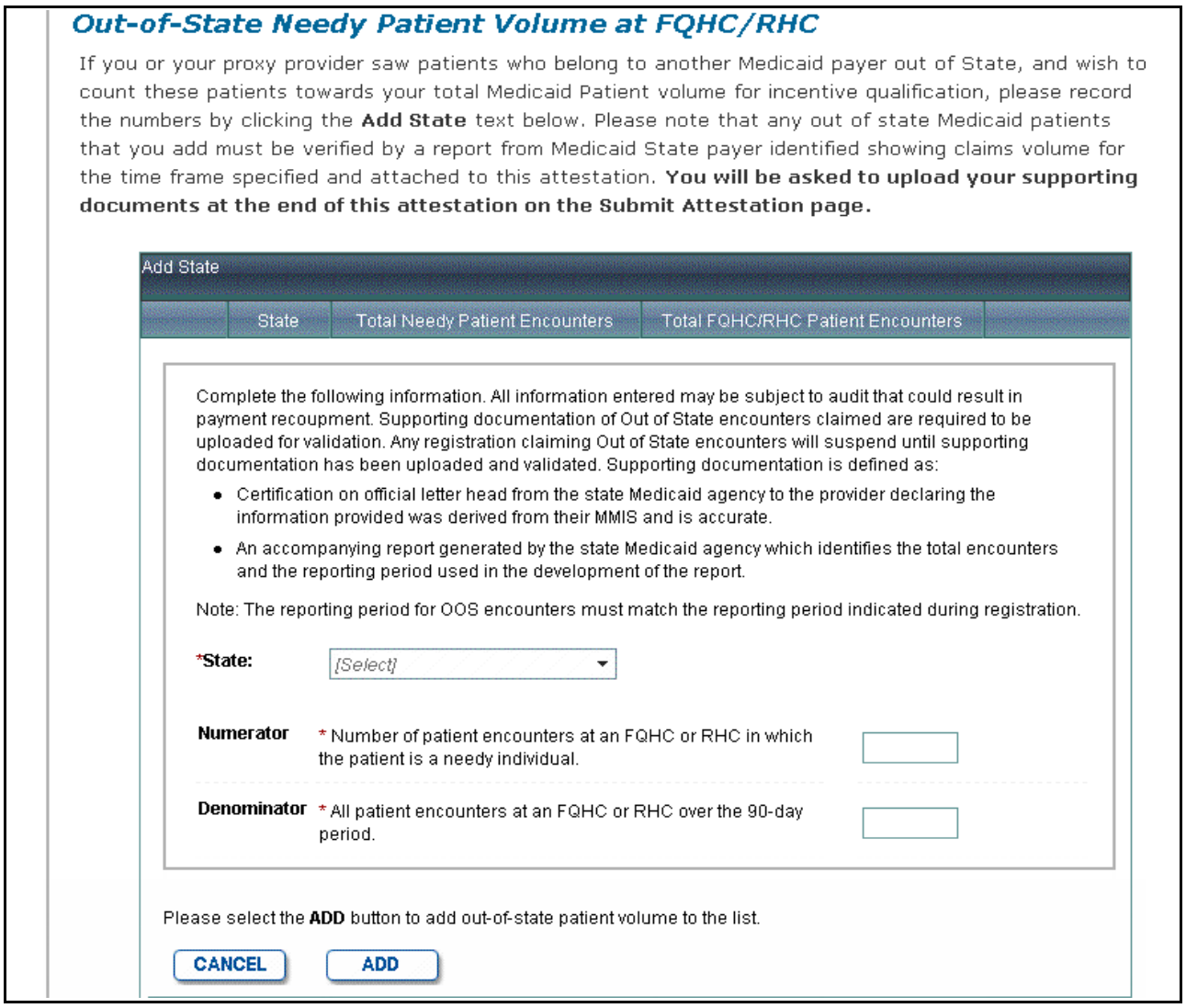

Out-of-State Needy Patient Volume at FQHC/RHC
If you or your proxy provider saw patients who belong to another Medicaid payer out of State, and wish to count these patients towards your total Medicaid Patient volume for incentive qualification, please record the numbers by clicking the Add State text below. Please note that any out of state Medicaid patients that you add must be verified by a report from Medicaid State payer identified showing claims volume for the time frame specified and attached to this attestation. You will be asked to upload your supporting documents at the end of this attestation on the Submit Attestation page.
Add State
State
Total Needy Patient Encounters
Total FQHC/RHC Patient Encounters
Complete the following information. All information entered may be subject to audit that could result in payment recoupment. Supporting documentation of Out of State encounters claimed are required to be uploaded for validation. Any registration claiming Out of State encounters will suspend until supporting documentation has been uploaded and validated. Supporting documentation is defined as:
Certification on official letter head from the state Medicaid agency to the provider declaring the information provided was derived from their MMIS and is accurate.
An accompanying report generated by the state Medicaid agency which identifies the total encounters and the reporting period used in the development of the report.
Note: The reporting period for OOS encounters must match the reporting period indicated during registration.
*State:
[Select]
Numerator
* Number of patient encounters at an FQHC or RHC in which the patient is a needy individual.
Denominator
* All patient encounters at an FQHC or RHC over the 90-day period.
Please select the ADD button to add out-of-state patient volume to the list.
CANCEL
ADD

Figure 38 - Attestation - Needy Out-of-State Patient Volume Entry/Edit Screen

2. Enter in each value. (Definitions of each field may be found in the Needy Patient volume section above.)
3. Select **Add**

- ❑ To Edit
  - ▪ Select **Edit** next to the state
  - ▪ The Out-of-State Patient Volume Entry screen displays with your entries
  - ▪ Modify the entries
  - ▪ Select **Update**
- ❑ To Delete
  - ▪ Select **Remove** on the desired state
  - ▪ Respond appropriately to the "Are you sure?" question

3. Select Save and Continue to save all changes.
4. The system validates if all fields have data entered.
   - – An error message displays if the user did not supply dates, numerator and a denominator. Please enter the appropriate data.
   - – If all fields have been answered AND THE PATIENT IS ELIGIBLE, the Incentive Payment schedule screen displays.
   - – If the provider does not meet the volume percentages listed above, the provider is ineligible and will not be allowed to continue. Attestation status will state Attestation Not Allowed. Contact USVI Medicaid Provider Services Help Desk at 855-248-7536 option 2 for questions and assistance.

10.4.2 Attestation Payment

The payment schedule is a proposed schedule based on the answers provided in the Eligibility section. Once a completed attestation is submitted to the USVI Medicaid EHR Incentive Program Attestation Application, it will execute USVI MMIS reports to validate the Medicaid patient encounter counts entered during the attestation process. If the entered Medicaid patient volume is not within a specified range of the USVI MMIS reported data, the application will not approve the attestation for payment and will refer the EP to the USVI Medicaid Provider Services Help Desk.

Pediatrician EHR Incentive Payments
(Between 20 – 29 Percent)

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	$14,167					
CY 2012	$5,667	$14,167				
CY 2013	$5,667	$5,667	$14,167			
CY 2014	$5,667	$5,667	$5,667	$14,167		
CY 2015	$5,667	$5,667	$5,667	$5,667	$14,167	
CY 2016	$5,665	$5,667	$5,667	$5,667	$5,667	$14,167
CY 2017		$5,665	$5,667	$5,667	$5,667	$5,667
CY 2018			$5,665	$5,667	$5,667	$5,667
CY 2019				$5,665	$5,667	$5,667
CY 2020					$5,665	$5,667
CY 2021						$5,665
TOTAL	$42,500	$42,500	$42,500	$42,500	$42,500	$42,500

Figure 39 - Pediatrician 20% volume payment calendar

Calendar of Payments for Providers						
Calendar Year	Medicaid EPs who begin adoption in					
	2011	2012	2013	2014	2015	2016
2011	$21,250					
2012	$8,500	$21,250				
2013	$8,500	$8,500	$21,250			
2014	$8,500	$8,500	$8,500	$21,250		
2015	$8,500	$8,500	$8,500	$8,500	$21,250	
2016	$8,500	$8,500	$8,500	$8,500	$8,500	$21,250
2017		$8,500	$8,500	$8,500	$8,500	$8,500
2018			$8,500	$8,500	$8,500	$8,500
2019				$8,500	$8,500	$8,500
2020					$8,500	$8,500
2021						$8,500
Total	$63,750	$63,750	$63,750	$63,750	$63,750	$63,750

Figure 40 - Eligible Providers payment calendar

10.4.3 Certified EHR Technology

The Office of the National Coordinator Authorized Testing and Certification Body (ONC-ATCB) is the body that tests and certifies electronic health record (EHR) systems. If the EHR system is approved, it is assigned a certification number. The website below is the Certified Health IT Product List website, http://onc-chpl.force.com/ehrcert, to look up your certified EHR technologies (CEHRT), add them to the cart, and then check out to obtain a EHR Certification

Number for your CEHRT. The figure below is the attestation screen to enter in the EHR certification number for the system you are using.

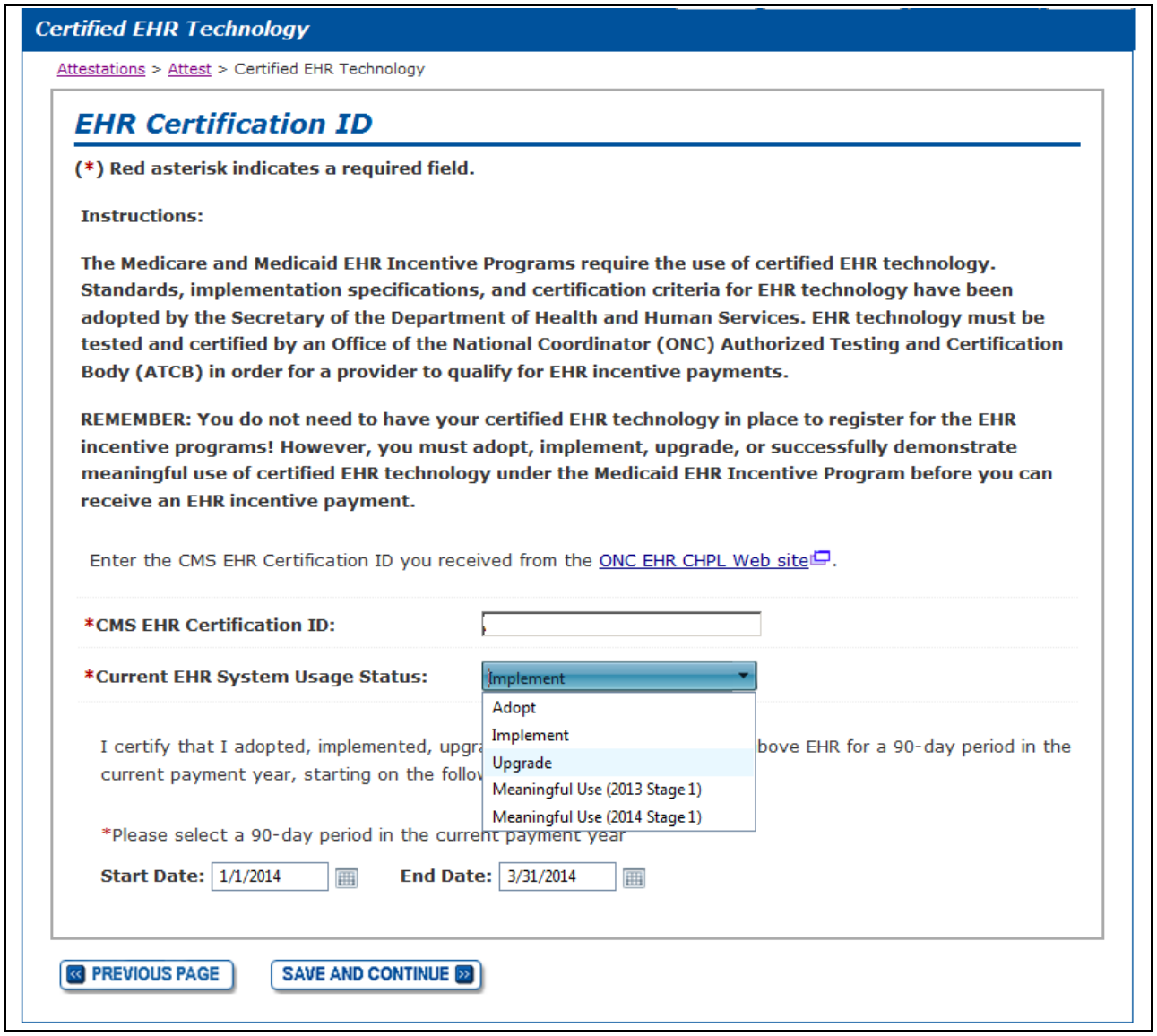

Certified EHR Technology
Attestations > Attest > Certified EHR Technology
EHR Certification ID
(*) Red asterisk indicates a required field.
Instructions:
The Medicare and Medicaid EHR Incentive Programs require the use of certified EHR technology. Standards, implementation specifications, and certification criteria for EHR technology have been adopted by the Secretary of the Department of Health and Human Services. EHR technology must be tested and certified by an Office of the National Coordinator (ONC) Authorized Testing and Certification Body (ATCB) in order for a provider to qualify for EHR incentive payments.
REMEMBER: You do not need to have your certified EHR technology in place to register for the EHR incentive programs! However, you must adopt, implement, upgrade, or successfully demonstrate meaningful use of certified EHR technology under the Medicaid EHR Incentive Program before you can receive an EHR incentive payment.
Enter the CMS EHR Certification ID you received from the ONC EHR CHPL Web site.
*CMS EHR Certification ID:
*Current EHR System Usage Status:
Implement
Adopt
Implement
Upgrade
Meaningful Use (2013 Stage 1)
Meaningful Use (2014 Stage 1)
I certify that I adopted, implemented, upgr
bove EHR for a 90-day period in the current payment year, starting on the follo
*Please select a 90-day period in the current payment year
Start Date: 1/1/2014
End Date: 3/31/2014
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 41 - Certified EHR Technology Page

1. Enter the EHR Certification number.
2. Select your current EHR system usage status.
3. Select the 90 day period that the EHR system was adopted, implemented, upgraded, or meaningful used based on your EHR usage
    - ❑ Type in dates or select a date via the Calendar function.
    - ❑ System will calculate the 90 days from the start or end date entered.

If AIU, select then

4. Select **Save and Continue**.

   - ❑ The system validates if all fields have data entered.
     - – Error message displays if the user did not:
       - supply EHR Certification number
       - select an option
       - supply a 90 day start and end date
       - enter the appropriate data
     - – If no errors occur, the Attestation Topic page displays. If all topics have been answered, the Submit button will be available.

If Meaningful Use 2013 or Meaningful Use 2014 is selected, then

5. Using the EHR Certification number, the system will validate if the EHR system is

   - ❑ 2011 Edition
     - Select Meaningful Use (2013 Stage 1) in dropdown
   - ❑ Combination of 2011 and 2014 Editions
     - Select either Meaningful Use (2013 Stage 1) or Meaningful Use (2014 Stage 1) in dropdown
   - ❑ 2014 Edition
     - Select Meaningful Use (2014 Stage 1) in dropdown.

6. Answer questions as shown in figure below.

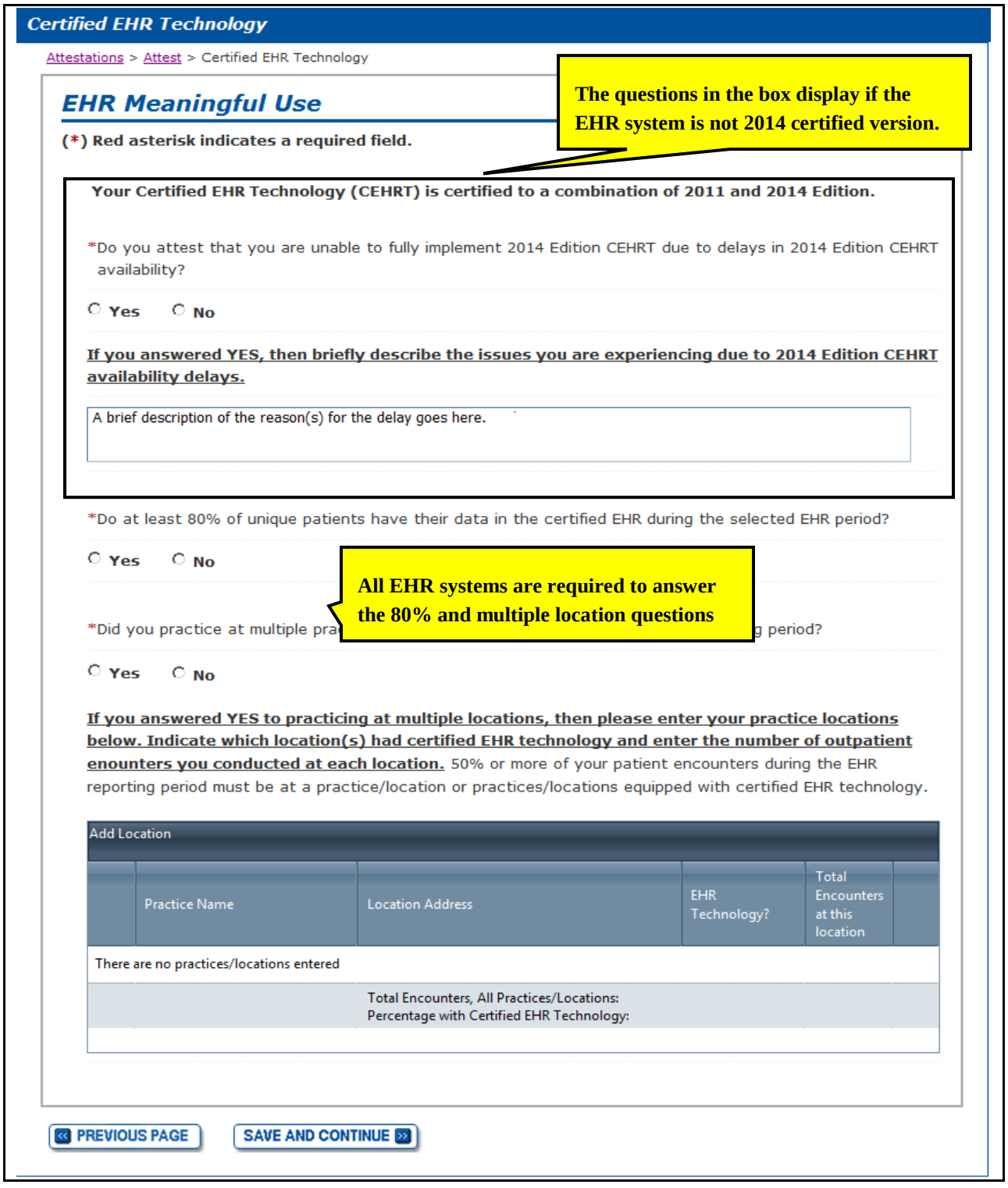

Certified EHR Technology
Attestations > Attest > Certified EHR Technology
EHR Meaningful Use
(*) Red asterisk indicates a required field.
The questions in the box display if the EHR system is not 2014 certified version.
Your Certified EHR Technology (CEHRT) is certified to a combination of 2011 and 2014 Edition.
*Do you attest that you are unable to fully implement 2014 Edition CEHRT due to delays in 2014 Edition CEHRT availability?
Yes
No
If you answered YES, then briefly describe the issues you are experiencing due to 2014 Edition CEHRT availability delays.
A brief description of the reason(s) for the delay goes here.
*Do at least 80% of unique patients have their data in the certified EHR during the selected EHR period?
Yes
No
All EHR systems are required to answer the 80% and multiple location questions
*Did you practice at multiple pra
g period?
Yes
No
If you answered YES to practicing at multiple locations, then please enter your practice locations below. Indicate which location(s) had certified EHR technology and enter the number of outpatient enounters you conducted at each location. 50% or more of your patient encounters during the EHR reporting period must be at a practice/location or practices/locations equipped with certified EHR technology.
Add Location
Practice Name
Location Address
EHR Technology?
Total Encounters at this location
There are no practices/locations entered
Total Encounters, All Practices/Locations:
Percentage with Certified EHR Technology:
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 42 -Certified EHR Questions if EHR not certified 2014 Edition

7. Select **Save and Continue**.

   - ❑ The system validates if all fields have data entered.

- Error message displays if the user did not:
  - supply EHR Certification number
  - select an option
  - supply a 90 day start and end date
  - enter the appropriate data
  - selected incorrect Meaningful use option for the certified EHR

8. If no errors occur, the Core Meaningful use questionnaire displays.

11. Meaningful Use Selected

If the EP selected "Meaningful Use" in the EHR Certified Technology page, the EP will need to provide responses to the meaningful use sections as outlined in the sections below.

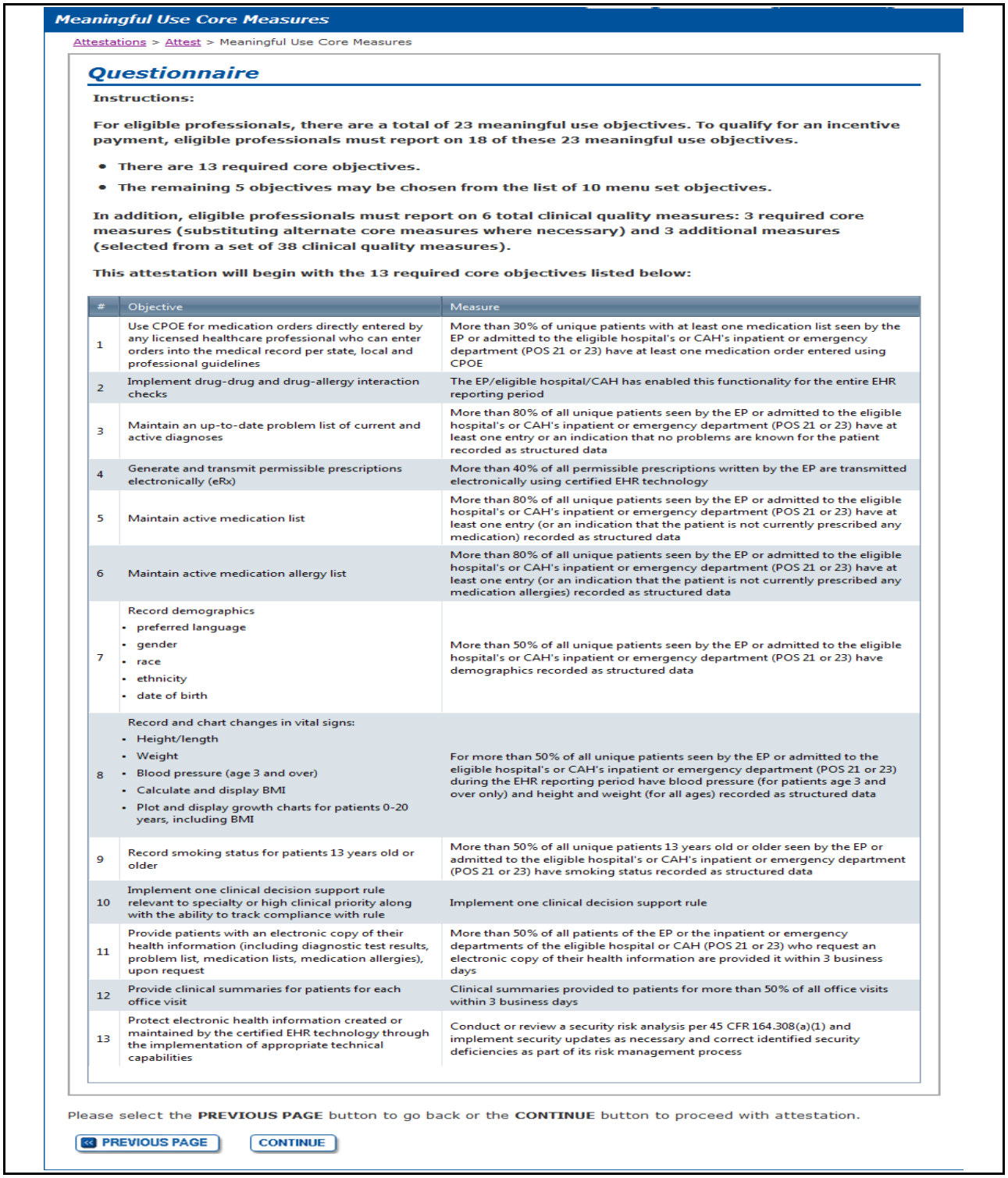
11.1 Meaningful Use Core Measures

The requirements for entry of meaningful use core measures are outlined below.

2013 Meaningful Use, CMS requires that EPs answer thirteen questions. .

2014 Meaningful use, CMS requires that EPs answer thirteen questions.

11.1.1 2013 Meaningful Use Core Measures



Meaningful Use Core Measures

Attestations > Attest > Meaningful Use Core Measures

Questionnaire

Instructions:

For eligible professionals, there are a total of 23 meaningful use objectives. To qualify for an incentive payment, eligible professionals must report on 18 of these 23 meaningful use objectives.

- **There are 13 required core objectives.**
- **The remaining 5 objectives may be chosen from the list of 10 menu set objectives.**

In addition, eligible professionals must report on 6 total clinical quality measures: 3 required core measures (substituting alternate core measures where necessary) and 3 additional measures (selected from a set of 38 clinical quality measures).

This attestation will begin with the 13 required core objectives listed below:

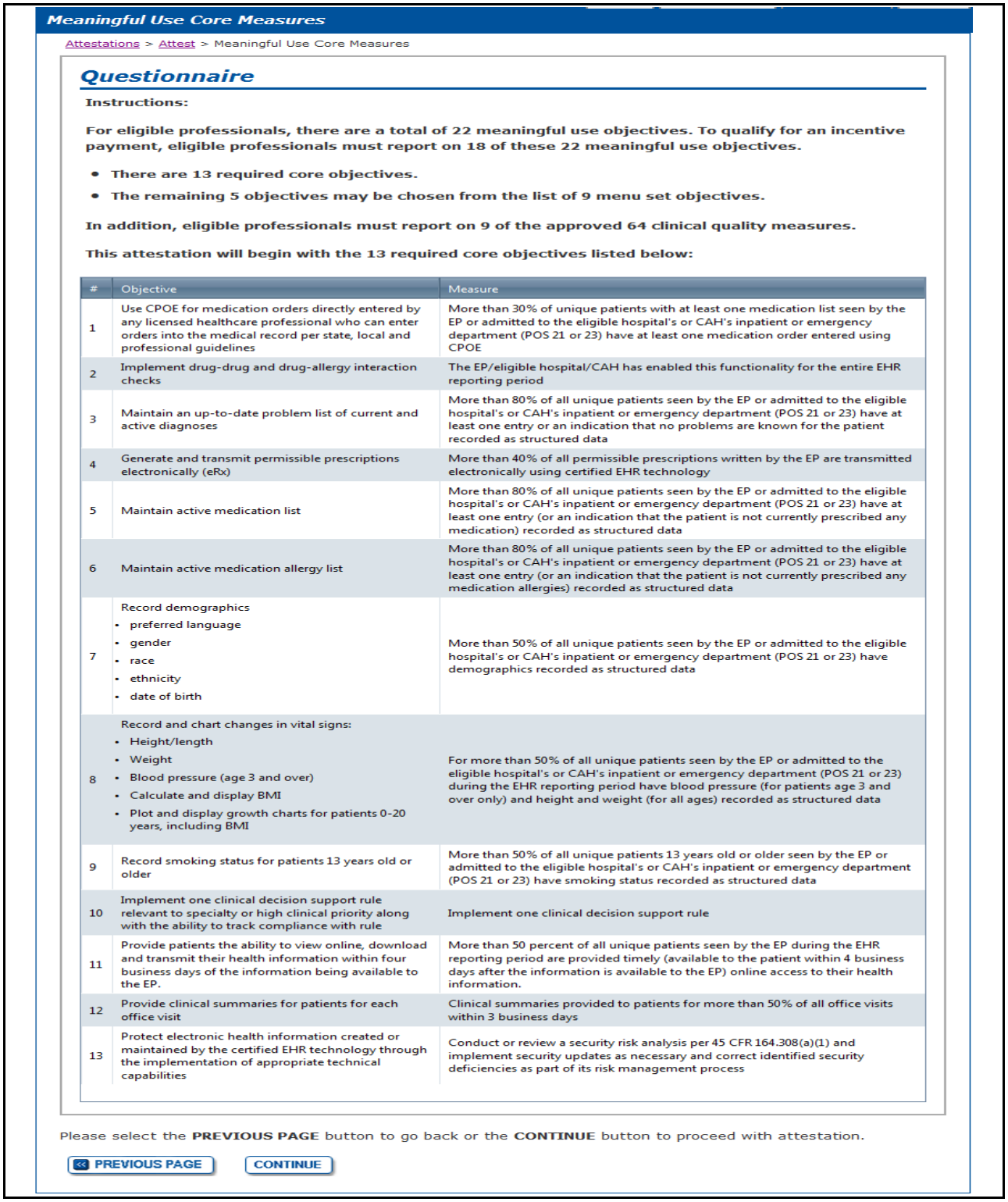
#	Objective	Measure
1	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
2	Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
3	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
4	Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
5	Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
6	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data
7	Record demographics • preferred language • gender • race • ethnicity • date of birth	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
8	Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	For more than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
9	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
10	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with rule	Implement one clinical decision support rule
11	Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request	More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
12	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
13	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Please select the **PREVIOUS PAGE** button to go back or the **CONTINUE** button to proceed with attestation.

PREVIOUS PAGE CONTINUE

Figure 43 - 2013 Meaningful Use Core Measures List

11.1.2 2014 Meaningful Use Core Measures



Meaningful Use Core Measures

Attestations > Attest > Meaningful Use Core Measures

Questionnaire

Instructions:

For eligible professionals, there are a total of 22 meaningful use objectives. To qualify for an incentive payment, eligible professionals must report on 18 of these 22 meaningful use objectives.

- **There are 13 required core objectives.**
- **The remaining 5 objectives may be chosen from the list of 9 menu set objectives.**

In addition, eligible professionals must report on 9 of the approved 64 clinical quality measures.

This attestation will begin with the 13 required core objectives listed below:

#	Objective	Measure
1	Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines	More than 30% of unique patients with at least one medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
2	Implement drug-drug and drug-allergy interaction checks	The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
3	Maintain an up-to-date problem list of current and active diagnoses	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
4	Generate and transmit permissible prescriptions electronically (eRx)	More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
5	Maintain active medication list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
6	Maintain active medication allergy list	More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data
7	Record demographics • preferred language • gender • race • ethnicity • date of birth	More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
8	Record and chart changes in vital signs: • Height/length • Weight • Blood pressure (age 3 and over) • Calculate and display BMI • Plot and display growth charts for patients 0-20 years, including BMI	For more than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
9	Record smoking status for patients 13 years old or older	More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
10	Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with rule	Implement one clinical decision support rule
11	Provide patients the ability to view online, download and transmit their health information within four business days of the information being available to the EP.	More than 50 percent of all unique patients seen by the EP during the EHR reporting period are provided timely (available to the patient within 4 business days after the information is available to the EP) online access to their health information.
12	Provide clinical summaries for patients for each office visit	Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
13	Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities	Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process

Please select the **PREVIOUS PAGE** button to go back or the **CONTINUE** button to proceed with attestation.

PREVIOUS PAGE CONTINUE

Figure 44 - Meaningful Use Core Measures List

EPs, please note that each MU question is required. The application will validate that all questions are completed during attestation, but does not validate that the responses entered meet the percentage threshold required for meaningful use of an EHR system until after the questionnaire is submitted. At this point, the system will reject the provider if the provider does not meet the requirement percentiles for appropriate EHR usage.

11.1.3 Meaningful Use Core Question General Workflow Functionality

Link to CMS definition

- Regardless of 2013 or 2014, each meaningful use measure screen has a link to the CMS definition for the applicable requirements and detail of each measure for the EP to access and review the specific requirements for completing the numerator/denominator for each measure and, if applicable, the criteria for being exempt from the particular meaningful use measure.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

- Displays the previous screen.

11.2 Meaningful Use Menu Measures

CMS requires that the provider must select a minimum of five questions and one question must be a public health question for any of the selected option of 2013 Meaningful Use, 2011 CEHRT or a combination of 2011 and 2014 CEHRT, or 2014 MU Stage 1.

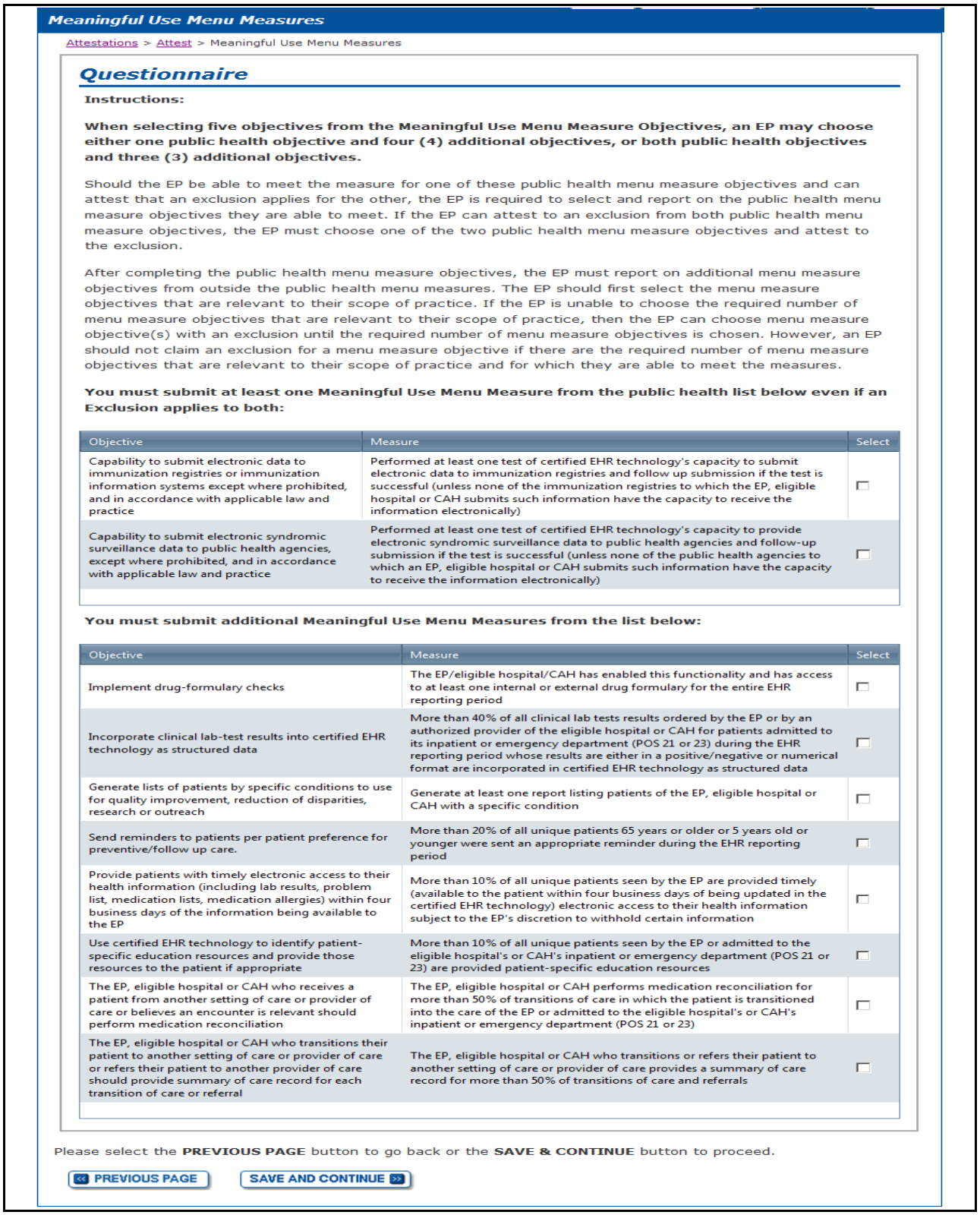

Meaningful Use Menu Measures
Attestations > Attest > Meaningful Use Menu Measures
Questionnaire
Instructions:
When selecting five objectives from the Meaningful Use Menu Measure Objectives, an EP may choose either one public health objective and four (4) additional objectives, or both public health objectives and three (3) additional objectives.
Should the EP be able to meet the measure for one of these public health menu measure objectives and can attest that an exclusion applies for the other, the EP is required to select and report on the public health menu measure objectives they are able to meet. If the EP can attest to an exclusion from both public health menu measure objectives, the EP must choose one of the two public health menu measure objectives and attest to the exclusion.
After completing the public health menu measure objectives, the EP must report on additional menu measure objectives from outside the public health menu measures. The EP should first select the menu measure objectives that are relevant to their scope of practice. If the EP is unable to choose the required number of menu measure objectives that are relevant to their scope of practice, then the EP can choose menu measure objective(s) with an exclusion until the required number of menu measure objectives is chosen. However, an EP should not claim an exclusion for a menu measure objective if there are the required number of menu measure objectives that are relevant to their scope of practice and for which they are able to meet the measures.
You must submit at least one Meaningful Use Menu Measure from the public health list below even if an Exclusion applies to both:
Objective
Measure
Select
Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice
Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)
Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice
Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)
You must submit additional Meaningful Use Menu Measures from the list below:
Objective
Measure
Select
Implement drug-formulary checks
The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
Incorporate clinical lab-test results into certified EHR technology as structured data
More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition
Send reminders to patients per patient preference for preventive/follow up care.
More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period
Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP
More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources
The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral
The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 45 - Meaningful Use Menu Measures List

- User must select at least one public health question and remaining questions to respond to by clicking in the box under the SELECT column for each question.
- A checkmark indicates that you have selected that question. The application will allow you to select more than the minimum 5 questions.

The following are the error messages if the minimum requirements are not meant:

MESSAGE 1- User receives the following error and cannot continue attestation process until error is fixed.

- If user does not select any questions
- If user does not select any public health question

Meaningful Use Menu Measures
Attestations > Attest > Meaningful Use Menu Measures
Questionnaire
You must resolve the following error(s) to continue:
Please select at least one public health measure.
Instructions:

MESSAGE 2 - User receives the following error and cannot continue attestation process until error is fixed.

- If the user selects less than 5 items, which includes a public health question, the following error message displays.

Meaningful Use Menu Measures
Attestations > Attest > Meaningful Use Menu Measures
Questionnaire
You must resolve the following error(s) to continue:
Please select 5 menu measures.

The application will only display the questions that were selected. The navigation is the same as was outlined in the Meaningful Use Core Measures section, as shown again below.

The application will not validate if the required score has been met at the time of entry, it will only tell the user if the appropriate questions have been completed or not. **The validation of meaningful use measures percentages is done after the attestation is submitted.**

11.2.1 Meaningful Use Question General Workflow Functionality

Link to CMS definition

- Each meaningful use measure screen has a link to the CMS definition for the applicable requirements and detail of each measure for the EP to access and review the specific requirements for completing the numerator/denominator for each measure and, if applicable, the criteria for being exempt from the particular meaningful use measure.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

- Displays the previous screen.

11.3 Clinical Quality Measures

CMS instructions for Clinical Quality Measure (CQMs) are for 2013 CQMs which the provider can select if they are using 2011 CEHRT or a combination of 2011 and 2014 CEHRT and they choose 2013 MU Stage 1. If the provider chooses 2014 MU Stage 1, the provider must choose 9 out of 64 available CQMs.

11.3.1 2013 MU Stage 1 Clinical Quality Measure Entry

CMS instructions for 2013 MU Stage 1 Clinical Quality Measure entry follows:

- Select of at least one public health measure from the list
- If the denominator of any of the core measures is zero, the provider will be required to answer three additional clinical quality measures.
- Select the remaining number of the required count from thirty-eight questions.

The following are the error messages if the minimum requirements are not meant:

MESSAGE 1- User receives the following error and cannot continue attestation process until error is fixed.

- If user does not select any questions

Meaningful Use Menu Measures
Attestations > Attest > Meaningful Use Menu Measures
Questionnaire
You must resolve the following error(s) to continue:
• Please select at least one public health measure.
Instructions:

MESSAGE 2 - User receives the following error and cannot continue attestation process until error is fixed.

- If the user selects less than 5 items, which includes a public health question, the following error message displays.

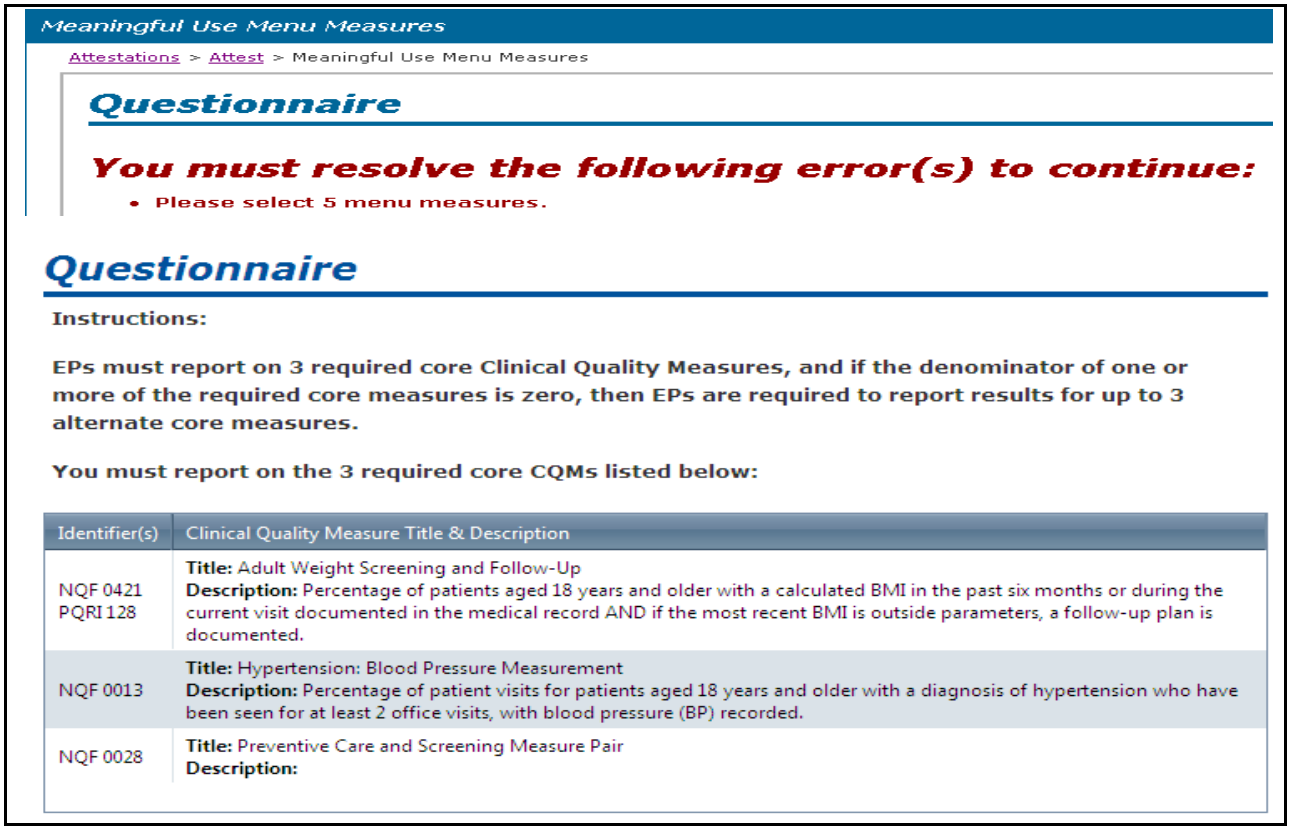

Meaningful Use Menu Measures
Attestations > Attest > Meaningful Use Menu Measures
Questionnaire
You must resolve the following error(s) to continue:
Please select 5 menu measures.
Questionnaire
Instructions:
EPs must report on 3 required core Clinical Quality Measures, and if the denominator of one or more of the required core measures is zero, then EPs are required to report results for up to 3 alternate core measures.
You must report on the 3 required core CQMs listed below:
Identifier(s)
Clinical Quality Measure Title & Description
NQF 0421 PQRI 128
Title: Adult Weight Screening and Follow-Up
Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
NQF 0013
Title: Hypertension: Blood Pressure Measurement
Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
NQF 0028
Title: Preventive Care and Screening Measure Pair
Description:

Figure 46 - 2013 Clinical Quality Measure Core List

If the provider responds with a zero in the denominator in the above questions, the following questions requires a response.

Questionnaire
Instructions:
You have entered zero for the denominator of 3 Core Clinical Quality Measure(s), therefore, you must report on 3 Alternate Core Clinical Quality Measure(s).
You must submit 3 Alternate Core Clinical Quality Measure(s) from the list below:
Identifier(s)
Clinical Quality Measure Title & Description
Select
NQF 0041 PQRI 110
Title: Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old
Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
NQF 0024
Title: Weight Assessment and Counseling for Children and Adolescents
Description: The percentage of patients 2-17 years of age who had an outpatient visit with a PCP or OBGYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.
NQF 0038
Title: Childhood Immunization Status
Description: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), two H influenza type B (HiB), three hepatitis B (Hep B), one chicken pox (VZV), four pneumococcal conjugate (PCV), two hepatitis A (Hep A), two or three rotavirus (RV), and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 47 - 2013 Clinical Quality Measures if zero in denominator

The EP needs to select the remaining number of the required count from thirty-eight questions. The following figure displays the list of questions. The individual question screen shot is displayed in the Clinical Quality Measures – 38 questions Screen Shots section.

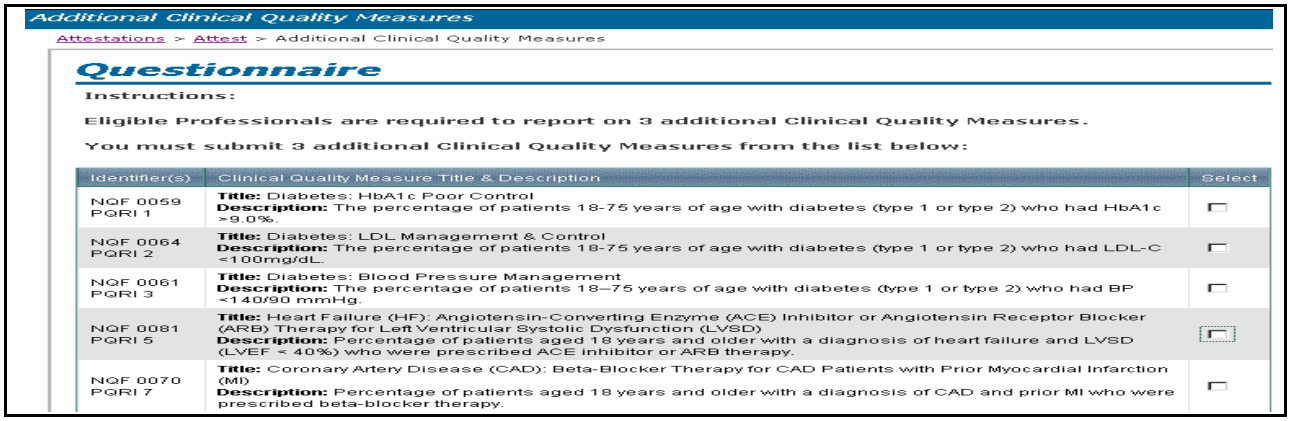

Additional Clinical Quality Measures
Attestations > Attest > Additional Clinical Quality Measures
Questionnaire
Instructions:
Eligible Professionals are required to report on 3 additional Clinical Quality Measures.
You must submit 3 additional Clinical Quality Measures from the list below:
Identifier(s)
Clinical Quality Measure Title & Description
Select
NQF 0059 PQRI 1
Title: Diabetes: HbA1c Poor Control
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.
NQF 0064 PQRI 2
Title: Diabetes: LDL Management & Control
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.
NQF 0061 PQRI 3
Title: Diabetes: Blood Pressure Management
Description: The percentage of patients 18–75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.
NQF 0081 PQRI 5
Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
NQF 0070 PQRI 7
Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.

Figure 48 - 2013 Clinical Quality Measures Beginning of 38 CQMs

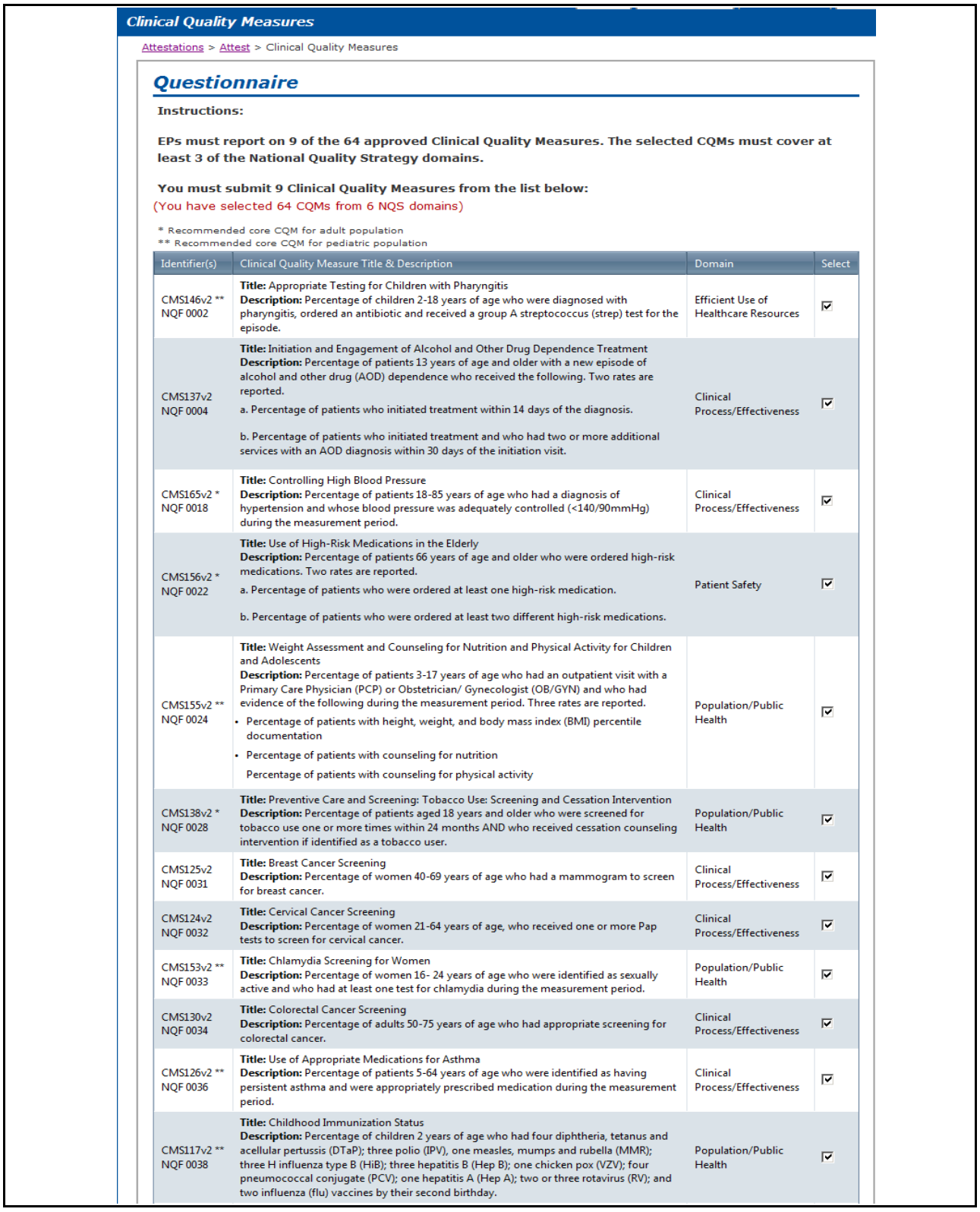
NQF 0089 PQRI 19
Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
NQF 0047 PQRI 53
Title: Asthma Pharmacologic Therapy
Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
NQF 0001 PQRI 64
Title: Asthma Assessment
Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
NQF 0002 PQRI 66
Title: Appropriate Testing for Children with Pharyngitis
Description: The percentage of children 2-18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
NQF 0387 PQRI 71
Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
NQF 0385 PQRI 72
Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.
NQF 0389 PQRI 102
Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
NQF 0027 PQRI 115
Title: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies
Description: The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
NQF 0055 PQRI 117
Title: Diabetes: Eye Exam
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.
NQF 0062 PQRI 119
Title: Diabetes: Urine Screening
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
NQF 0056 PQRI 163
Title: Diabetes: Foot Exam
Description: The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
NQF 0074 PQRI 197
Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
NQF 0084 PQRI 200
Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
Description: Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
NQF 0073 PQRI 201
Title: Ischemic Vascular Disease (IVD): Blood Pressure Management
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1– November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).

NQF 0068 PQRI 204
Title: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1—November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.
NQF 0004
Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
NQF 0012
Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit.
NQF 0014
Title: Prenatal Care: Anti-D Immune Globulin
Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
NQF 0018
Title: Controlling High Blood Pressure
Description: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
NQF 0032
Title: Cervical Cancer Screening
Description: The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.
NQF 0033
Title: Chlamydia Screening for Women
Description: The percentage of women 16-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
NQF 0036
Title: Use of Appropriate Medications for Asthma
Description: The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
NQF 0052
Title: Low Back Pain: Use of Imaging Studies
Description: The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.
NQF 0075
Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1— November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.
NQF 0575
Title: Diabetes: HbA1c Control < 8%
Description: The percentage of patients 18—75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 49 - 2013 Clinical Quality Measures remaining of the 38 CQMs

11.3.2 2014 MU Stage 1 Clinical Quality Measure Entry

CMS requires that EPS report on 9 of the 64 CQMs and selected CQMs are from at least 3 of the National Quality Strategy (NQS) domains. The Domain column in the selection list indicates the NQS.



Clinical Quality Measures

Attestations > Attest > Clinical Quality Measures

Questionnaire

Instructions:

EPs must report on 9 of the 64 approved Clinical Quality Measures. The selected CQMs must cover at least 3 of the National Quality Strategy domains.

You must submit 9 Clinical Quality Measures from the list below:

(You have selected 64 CQMs from 6 NQS domains)

* Recommended core CQM for adult population
** Recommended core CQM for pediatric population

Identifier(s)	Clinical Quality Measure Title & Description	Domain	Select
CMS146v2 ** NQF 0002	**Title:** Appropriate Testing for Children with Pharyngitis **Description:** Percentage of children 2-18 years of age who were diagnosed with pharyngitis, ordered an antibiotic and received a group A streptococcus (strep) test for the episode.	Efficient Use of Healthcare Resources	☑
CMS137v2 NQF 0004	**Title:** Initiation and Engagement of Alcohol and Other Drug Dependence Treatment **Description:** Percentage of patients 13 years of age and older with a new episode of alcohol and other drug (AOD) dependence who received the following. Two rates are reported. a. Percentage of patients who initiated treatment within 14 days of the diagnosis. b. Percentage of patients who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.	Clinical Process/Effectiveness	☑
CMS165v2 * NQF 0018	**Title:** Controlling High Blood Pressure **Description:** Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.	Clinical Process/Effectiveness	☑
CMS156v2 * NQF 0022	**Title:** Use of High-Risk Medications in the Elderly **Description:** Percentage of patients 66 years of age and older who were ordered high-risk medications. Two rates are reported. a. Percentage of patients who were ordered at least one high-risk medication. b. Percentage of patients who were ordered at least two different high-risk medications.	Patient Safety	☑
CMS155v2 ** NQF 0024	**Title:** Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents **Description:** Percentage of patients 3-17 years of age who had an outpatient visit with a Primary Care Physician (PCP) or Obstetrician/ Gynecologist (OB/GYN) and who had evidence of the following during the measurement period. Three rates are reported. • Percentage of patients with height, weight, and body mass index (BMI) percentile documentation • Percentage of patients with counseling for nutrition Percentage of patients with counseling for physical activity	Population/Public Health	☑
CMS138v2 * NQF 0028	**Title:** Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention **Description:** Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.	Population/Public Health	☑
CMS125v2 NQF 0031	**Title:** Breast Cancer Screening **Description:** Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	Clinical Process/Effectiveness	☑
CMS124v2 NQF 0032	**Title:** Cervical Cancer Screening **Description:** Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer.	Clinical Process/Effectiveness	☑
CMS153v2 ** NQF 0033	**Title:** Chlamydia Screening for Women **Description:** Percentage of women 16- 24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement period.	Population/Public Health	☑
CMS130v2 NQF 0034	**Title:** Colorectal Cancer Screening **Description:** Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.	Clinical Process/Effectiveness	☑
CMS126v2 ** NQF 0036	**Title:** Use of Appropriate Medications for Asthma **Description:** Percentage of patients 5-64 years of age who were identified as having persistent asthma and were appropriately prescribed medication during the measurement period.	Clinical Process/Effectiveness	☑
CMS117v2 ** NQF 0038	**Title:** Childhood Immunization Status **Description:** Percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV), one measles, mumps and rubella (MMR); three H influenza type B (HiB); three hepatitis B (Hep B); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday.	Population/Public Health	☑

Figure 50 - 2014 Clinical Quality Measures

CMS147v2 NQF 0041	**Title:** Preventive Care and Screening: Influenza Immunization **Description:** Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.	Population/Public Health	☑
CMS127v2 NQF 0043	**Title:** Pneumonia Vaccination Status for Older Adults **Description:** Percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.	Clinical Process/Effectiveness	☑
CMS166v3 * NQF 0052	**Title:** Use of Imaging Studies for Low Back Pain **Description:** Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis.	Efficient Use of Healthcare Resources	☑
CMS131v2 NQF 0055	**Title:** Diabetes: Eye Exam **Description:** Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period.	Clinical Process/Effectiveness	☑
CMS123v2 NQF 0056	**Title:** Diabetes: Foot Exam **Description:** Percentage of patients aged 18-75 years of age with diabetes who had a foot exam during the measurement period.	Clinical Process/Effectiveness	☑
CMS122v2 NQF 0059	**Title:** Diabetes: Hemoglobin A1c Poor Control **Description:** Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.	Clinical Process/Effectiveness	☑
CMS148v2 NQF 0060	**Title:** Hemoglobin A1c Test for Pediatric Patients **Description:** Percentage of patients 5-17 years of age with diabetes with an HbA1c test during the measurement period.	Clinical Process/Effectiveness	☑
CMS134v2 NQF 0062	**Title:** Diabetes: Urine Protein Screening **Description:** The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Clinical Process/Effectiveness	☑
CMS163v2 NQF 0064	**Title:** Diabetes: Low Density Lipoprotein (LDL) Management **Description:** Percentage of patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (<100 mg/dL) during the measurement period.	Clinical Process/Effectiveness	☑
CMS164v2 NQF 0068	**Title:** Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic **Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had documentation of use of aspirin or another antithrombotic during the measurement period.	Clinical Process/Effectiveness	☑
CMS154v2 ** NQF 0069	**Title:** Appropriate Treatment for Children with Upper Respiratory Infection (URI) **Description:** Percentage of children 3 months-18 years of age who were diagnosed with upper respiratory infection (URI) and were not dispensed an antibiotic prescription on or three days after the episode.	Efficient Use of Healthcare Resources	☑
CMS145v2 NQF 0070	**Title:** Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%) **Description:** Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have a prior MI or a current or prior LVEF <40% who were prescribed beta-blocker therapy.	Clinical Process/Effectiveness	☑
CMS182v3 NQF 0075	**Title:** Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control **Description:** Percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) in the 12 months prior to the measurement period, or who had an active diagnosis of ischemic vascular disease (IVD) during the measurement period, and who had a complete lipid profile performed during the measurement period and whose LDL-C was adequately controlled (< 100 mg/dL).	Clinical Process/Effectiveness	☑
CMS135v2 NQF 0081	**Title:** Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Clinical Process/Effectiveness	☑
CMS144v2 NQF 0083	**Title:** Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) **Description:** Percentage of patients aged 18 years and older with a diagnosis of heart failure (HF) with a current or prior left ventricular ejection fraction (LVEF) < 40% who were prescribed beta-blocker therapy either within a 12 month period when seen in the outpatient setting OR at each hospital discharge.	Clinical Process/Effectiveness	☑
CMS143v2 NQF 0086	**Title:** Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation **Description:** Percentage of patients aged 18 years and older with a diagnosis of primary open-angle glaucoma (POAG) who have an optic nerve head evaluation during one or more office visits within 12 months.	Clinical Process/Effectiveness	☑
CMS167v2 NQF 0088	**Title:** Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy **Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.	Clinical Process/Effectiveness	☑
CMS142v2 NQF 0089	**Title:** Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care **Description:** Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the ongoing care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.	Clinical Process/Effectiveness	☑
CMS139v2 NQF 0101	**Title:** Falls: Screening for Future Fall Risk **Description:** Percentage of patients 65 years of age and older who were screened for future fall risk during the measurement period.	Patient Safety	☑
CMS161v2 NQF 0104	**Title:** Adult Major Depressive Disorder (MDD): Suicide Risk Assessment **Description:** Percentage of patients aged 18 years and older with a diagnosis of major depressive disorder (MDD) with a suicide risk assessment completed during the visit in which a new diagnosis or recurrent episode was identified.	Clinical Process/Effectiveness	☑
CMS128v2 NQF 0105	**Title:** Anti-depressant Medication Management **Description:** Percentage of patients 18 years of age and older who were diagnosed with major depression and treated with antidepressant medication, and who remained on antidepressant medication treatment. Two rates are reported. a. Percentage of patients who remained on an antidepressant medication for at least 84 days (12 weeks). b. Percentage of patients who remained on an antidepressant medication for at least 180 days (6 months).	Clinical Process/Effectiveness	☑
CMS136v3 ** NQF 0108	**Title:** ADHD: Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication **Description:** Percentage of children 6-12 years of age and newly dispensed a medication for attention-deficit/ hyperactivity disorder (ADHD) who had appropriate follow-up care. Two rates are reported. a. Percentage of children who had one follow-up visit with a practitioner with prescribing authority during the 30-Day Initiation Phase. b. Percentage of children who remained on ADHD medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two additional follow-up visits with a practitioner within 270 days (9 months) after the Initiation Phase ended.	Clinical Process/Effectiveness	☑

Figure 51 - 2014 Clinical Measures (continued)

CMS169v2 NQF 0110	**Title:** Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use **Description:** Percentage of patients with depression or bipolar disorder with evidence of an initial assessment that includes an appraisal for alcohol or chemical substance use.	Clinical Process/Effectiveness	☑
CMS157v2 NQF 0384	**Title:** Oncology: Medical and Radiation – Pain Intensity Quantified **Description:** Percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified.	Patient and Family Engagement	☑
CMS141v3 NQF 0385	**Title:** Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients **Description:** Percentage of patients aged 18 through 80 years with AJCC Stage III colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.	Clinical Process/Effectiveness	☑
CMS140v2 NQF 0387	**Title:** Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/ Progesterone Receptor (ER/PR) Positive Breast Cancer **Description:** Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.	Clinical Process/Effectiveness	☑
CMS129v3 NQF 0389	**Title:** Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients **Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.	Efficient Use of Healthcare Resources	☑
CMS62v2 NQF 0403	**Title:** HIV/AIDS: Medical Visit **Description:** Percentage of patients, regardless of age, with a diagnosis of HIV/AIDS with at least two medical visits during the measurement year with a minimum of 90 days between each visit.	Clinical Process/Effectiveness	☑
CMS52v2 NQF 0405	**Title:** HIV/AIDS: Pneumocystis jiroveci pneumonia (PCP) Prophylaxis **Description:** Percentage of patients aged 6 weeks and older with a diagnosis of HIV/AIDS who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis.	Clinical Process/Effectiveness	☑
CMS77v2	**Title:** HIV/AIDS: RNA Control for Patients with HIV **Description:** Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS, with at least two visits during the measurement year, with at least 90 days between each visit, whose most recent HIV RNA level is <200 copies/mL.	Clinical Process/Effectiveness	☑
CMS2v3 *,** NQF 0418	**Title:** Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan **Description:** Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow up plan is documented on the date of the positive screen.	Population/Public Health	☑
CMS68v3 * NQF 0419	**Title:** Documentation of Current Medications in the Medical Record **Description:** Percentage of visits for patients aged 18 years and older for which the eligible professional attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Patient Safety	☑
CMS69v2 * NQF 0421	**Title:** Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up **Description:** Percentage of patients aged 18 years and older with a documented BMI during the encounter or during the previous six months, AND when the BMI is outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the encounter Normal Parameters: Age 65 years and older BMI > = 23 and < 30 Age 18-64 years BMI > = 18.5 and < 25	Population/Public Health	☑
CMS132v2 NQF 0564	**Title:** Cataracts: Complications within 30 Days Following Cataract Surgery Requiring Additional Surgical Procedures **Description:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and had any of a specified list of surgical procedures in the 30 days following cataract surgery which would indicate the occurrence of any of the following major complications: retained nuclear fragments, endophthalmitis, dislocated or wrong power IOL, retinal detachment, or wound dehiscence.	Patient Safety	☑
CMS133v2 NQF 0565	**Title:** Cataracts: 20/40 or Better Visual Acuity within 90 Days Following Cataract Surgery **Description:** Percentage of patients aged 18 years and older with a diagnosis of uncomplicated cataract who had cataract surgery and no significant ocular conditions impacting the visual outcome of surgery and had best-corrected visual acuity of 20/40 or better (distance or near) achieved within 90 days following the cataract surgery.	Clinical Process/Effectiveness	☑
CMS158v2 NQF 0608	**Title:** Pregnant Women That Had HBsAg Testing **Description:** This measure identifies pregnant women who had a HBsAg (hepatitis B) test during their pregnancy.	Clinical Process/Effectiveness	☑
CMS159v2 NQF 0710	**Title:** Depression Remission at Twelve Months **Description:** Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment.	Clinical Process/Effectiveness	☑
CMS160v2 NQF 0712	**Title:** Depression Utilization of the PHQ-9 Tool **Description:** Adult patients age 18 and older with the diagnosis of major depression or dysthymia who have a PHQ-9 tool administered at least once during a 4 month period in which there was a qualifying visit.	Clinical Process/Effectiveness	☑
CMS75v2 **	**Title:** Children Who Have Dental Decay or Cavities **Description:** Percentage of children, age 0-20 years, who have had tooth decay or cavities during the measurement period.	Clinical Process/Effectiveness	☑
CMS177v2 NQF 1365	**Title:** Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment **Description:** Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.	Patient Safety	☑
CMS82v1 NQF 1401	**Title:** Maternal Depression Screening **Description:** The percentage of children who turned 6 months of age during the measurement year, who had a face-to-face visit between the clinician and the child during child's first 6 months, and who had a maternal depression screening for the mother at least once between 0 and 6 months of life.	Population/Public Health	☑
CMS74v3	**Title:** Primary Caries Prevention Intervention as Offered by Primary Care Providers, including Dentists **Description:** Percentage of children, age 0-20 years, who received a fluoride varnish application during the measurement period.	Clinical Process/Effectiveness	☑
CMS61v3	**Title:** Preventive Care and Screening: Cholesterol – Fasting Low Density Lipoprotein (LDL-C) Test Performed **Description:** Percentage of patients aged 20 through 79 years whose risk factors have been assessed and a fasting LDL-C test has been performed.	Clinical Process/Effectiveness	☑
CMS64v3	**Title:** Preventive Care and Screening: Risk-Stratified Cholesterol – Fasting Low Density Lipoprotein (LDL-C) **Description:** Percentage of patients aged 20 through 79 years who had a fasting LDL-C test performed and whose risk-stratified fasting LDL-C is at or below the recommended LDL-C goal.	Clinical Process/Effectiveness	☑
CMS149v2	**Title:** Dementia: Cognitive Assessment **Description:** Percentage of patients, regardless of age, with a diagnosis of dementia for whom an assessment of cognition is performed and the results reviewed at least once within a 12 month period.	Clinical Process/Effectiveness	☑
CMS65v3	**Title:** Hypertension: Improvement in Blood Pressure **Description:** Percentage of patients aged 18-85 years of age with a diagnosis of hypertension whose blood pressure improved during the measurement period.	Clinical Process/Effectiveness	☑
CMS50v2 *	**Title:** Closing the Referral Loop: Receipt of Specialist Report **Description:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Care Coordination	☑
CMS66v2	**Title:** Functional Status Assessment for Knee Replacement **Description:** Percentage of patients aged 18 years and older with primary total knee arthroplasty (TKA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patient and Family Engagement	☑
CMS56v2	**Title:** Functional Status Assessment for Hip Replacement **Description:** Percentage of patients aged 18 years and older with primary total hip arthroplasty (THA) who completed baseline and follow-up (patient-reported) functional status assessments.	Patient and Family Engagement	☑
CMS90v3 *	**Title:** Functional Status Assessment for Complex Chronic Conditions **Description:** Percentage of patients aged 65 years and older with heart failure who completed initial and follow-up patient-reported functional status assessments.	Patient and Family Engagement	☑
CMS179v2	**Title:** ADE Prevention and Monitoring: Warfarin Time in Therapeutic Range **Description:** Average percentage of time in which patients aged 18 and older with atrial fibrillation who are on chronic warfarin therapy have International Normalized Ratio (INR) test results within the therapeutic range (i.e., TTR) during the measurement period.	Patient Safety	☑

Figure 52 - 2014 Clinical Measures (continued)

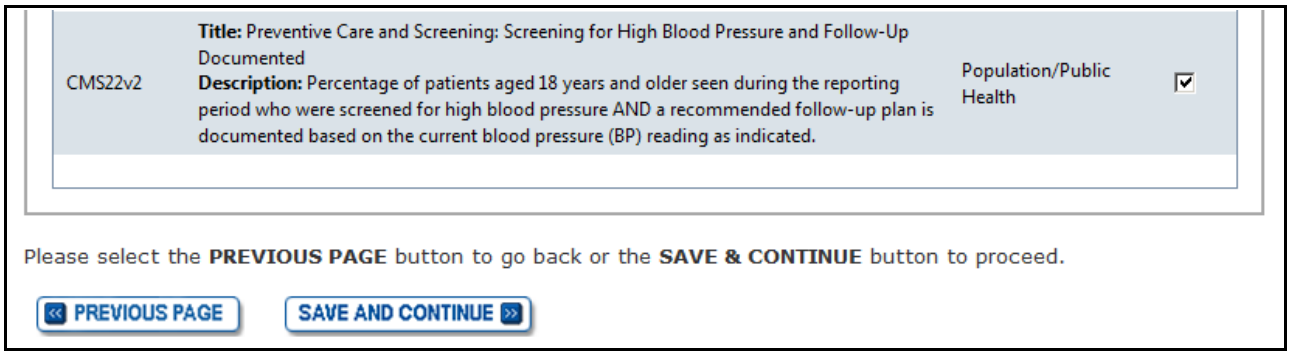

CMS22v2
Title: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented
Description: Percentage of patients aged 18 years and older seen during the reporting period who were screened for high blood pressure AND a recommended follow-up plan is documented based on the current blood pressure (BP) reading as indicated.
Population/Public Health
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Figure 53 - 2014 Clinical Measures

11.3.3 Clinical Quality Measures Meaningful Use Question General Workflow Functionality

To complete the CQM section, CMS instructions for 2013 CQMs which the provider can select if they are using 2011 CEHRT or a combination of 2011 and 2014 CEHRT and they choose 2013 MU Stage 1. If the provider chooses 2014 MU Stage 1, the provider must choose 9 out of 64 available CQMs. The navigation is the same as was outlined in the Meaningful Use Core and Menu Measures section, but are repeated below.

The following are the error messages if the minimum requirements are not meet.

MESSAGE - The error message displays the number of questions that need to be selected to meet the minimum requirement.

You must resolve the following error(s) to continue:
Please select 3 Additional Clinical Quality Measures.
You must resolve the following error(s) to continue:
Please select 2 more Additional Clinical Quality Measures.
You must resolve the following error(s) to continue:
Please select 1 more Additional Clinical Quality Measure.

Link to CMS definition

- Each clinical quality measure screen has a link to the CMS definition for the applicable requirements and detail of each measure for the EP to access and review the specific requirements for completing the numerator/denominator for each measure and, if applicable, the criteria for being exempt from the particular clinical quality measure.

Save and Continue Button

- When selected, a check is executed to determine if all required fields have information entered.
  - If required fields are not completed, the page will continue to display until required fields are corrected.
  - If required fields are completed, the next screen displays.

Previous Button

Displays the previous screen

12. Submit Attestation and payment status

The Submit & Attest button remains disabled if the eligibility checks failed or not all required questions have been answered. If the eligibility checks passed and all required questions are answered, then the Submit & Attest button is available. On selection of the Submit & Attest button, the following screen displays.

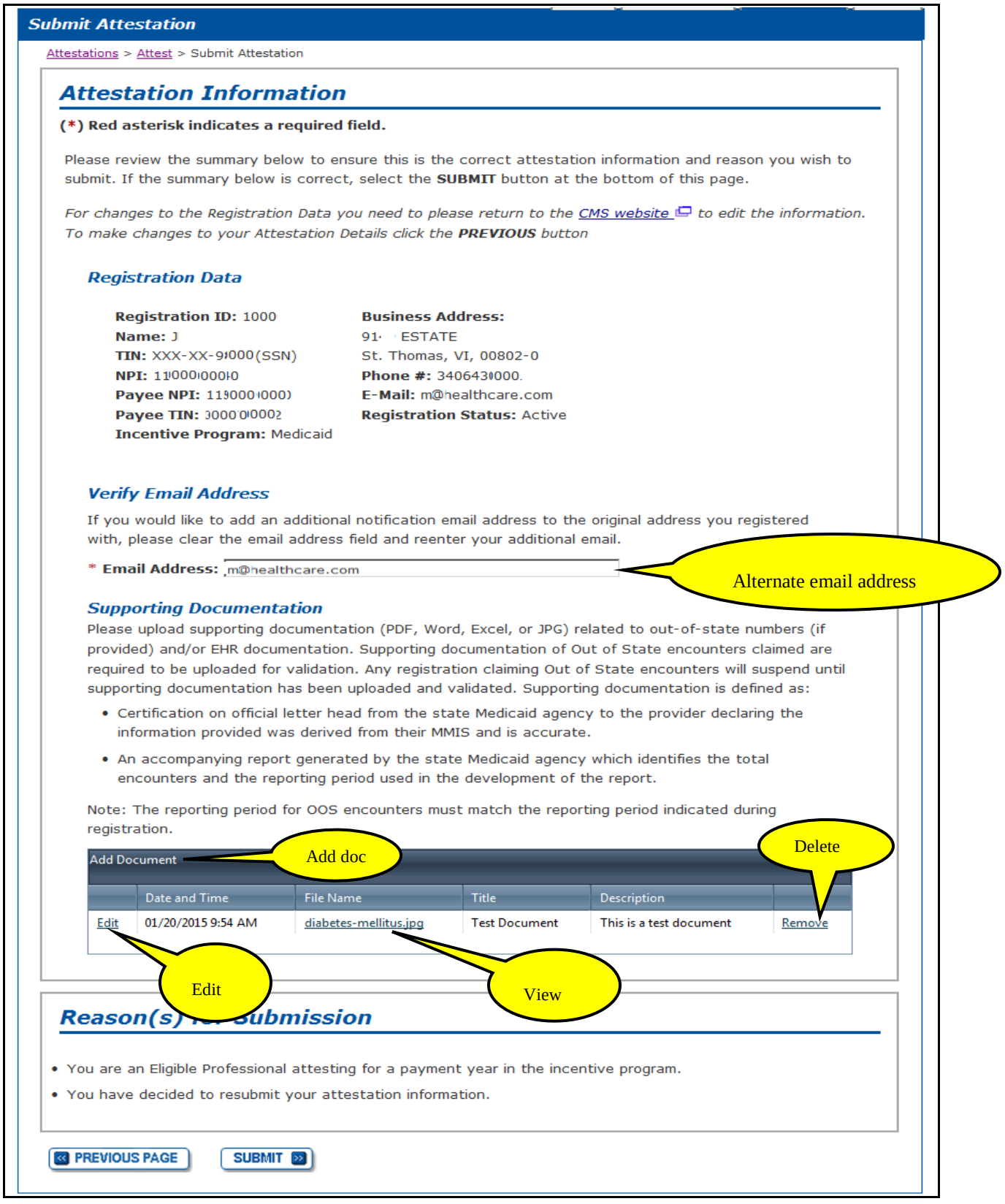

Submit Attestation
Attestations > Attest > Submit Attestation
Attestation Information
(*) Red asterisk indicates a required field.
Please review the summary below to ensure this is the correct attestation information and reason you wish to submit. If the summary below is correct, select the SUBMIT button at the bottom of this page.
For changes to the Registration Data you need to please return to the CMS website to edit the information.
To make changes to your Attestation Details click the PREVIOUS button
Registration Data
Registration ID: 1000
Name: J
TIN: XXX-XX-9000 (SSN)
NPI: 1100000000
Payee NPI: 1100000000
Payee TIN: 300000002
Incentive Program: Medicaid
Business Address:
91 ESTATE
St. Thomas, VI, 00802-0
Phone #: 3406430000
E-Mail: m@healthcare.com
Registration Status: Active
Verify Email Address
If you would like to add an additional notification email address to the original address you registered with, please clear the email address field and reenter your additional email.
* Email Address: m@healthcare.com
Alternate email address
Supporting Documentation
Please upload supporting documentation (PDF, Word, Excel, or JPG) related to out-of-state numbers (if provided) and/or EHR documentation. Supporting documentation of Out of State encounters claimed are required to be uploaded for validation. Any registration claiming Out of State encounters will suspend until supporting documentation has been uploaded and validated. Supporting documentation is defined as:
Certification on official letter head from the state Medicaid agency to the provider declaring the information provided was derived from their MMIS and is accurate.
An accompanying report generated by the state Medicaid agency which identifies the total encounters and the reporting period used in the development of the report.
Note: The reporting period for OOS encounters must match the reporting period indicated during registration.
Add Document
Add doc
Delete
Date and Time
File Name
Title
Description
Edit
01/20/2015 9:54 AM
diabetes-mellitus.jpg
Test Document
This is a test document
Remove
Edit
View
Reason(s) for Submission
You are an Eligible Professional attesting for a payment year in the incentive program.
You have decided to resubmit your attestation information.
PREVIOUS PAGE
SUBMIT

Figure 54 - Attestation Tab - Submit Attestation Check Email Address

12.1 Supporting Documentation

Documents supporting any of the information entered into the Attestation Application may be uploaded here. Documents may be in the form of PDF, Jpeg, Microsoft Excel, and Microsoft Word files and must be 4 megabytes or smaller. Section 3 of this document lists required documentation. If you have entered out-of-state encounters, you are required to upload two documents, which are a certification letter that patient volumes entered are from the other state's MMIS and the report from the state's MMIS.

- ❑ To Add Document

1. Select **Add Document** to display the following screen:

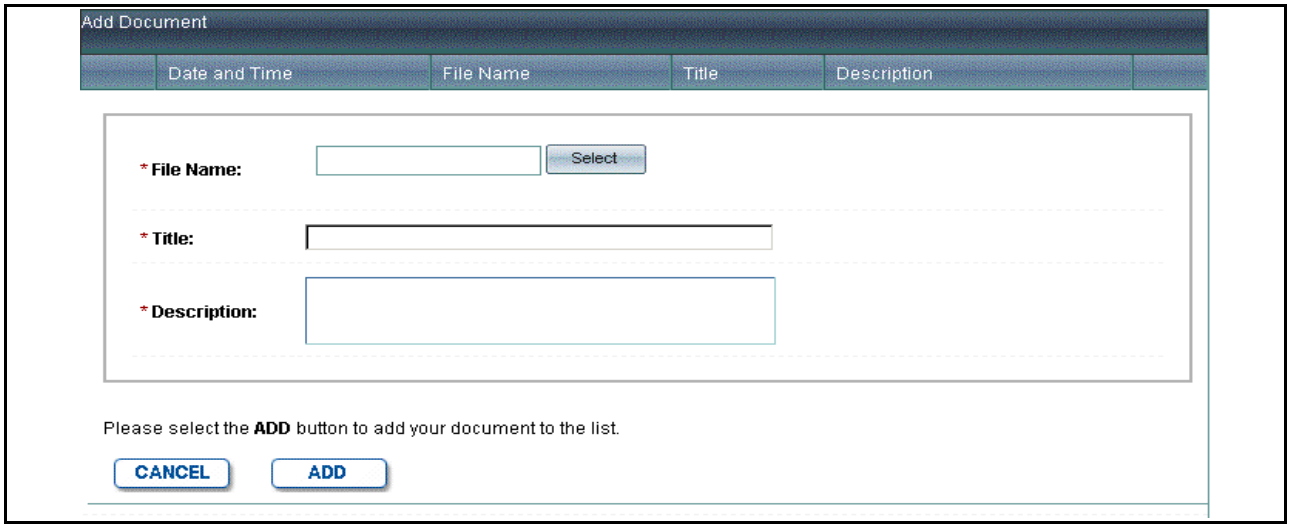


Figure 55 - Submit Attestation - Supporting Documentation - Add Screen

- ❑Select **File** to upload the supporting document from your computer
- ❑Select the **Select** button
- ❑On "Files" window, navigate through your computer and select the file to upload,
- ❑Select **OK**.
- ❑Document name displays in the "File Name" box.

2. Enter a title for the document (required)
3. Enter a description of the file (required)
4. Select **Add**

- ❑ To add more files, repeat steps 1 – 4.

- ❑ To edit a document:

1. Select Edit next to the desired document
2. The "Supporting Documentation – Add" screen fields displays with **Update** and **Cancel** buttons instead.
3. Modify the information
4. Select **Update**

- ❑ To delete a document

1. Select **Remove** next to the desired document
2. Answer "**Are you sure**?" question appropriately
3. Select Submit button. This displays the Successful Submission screen. An example is below.

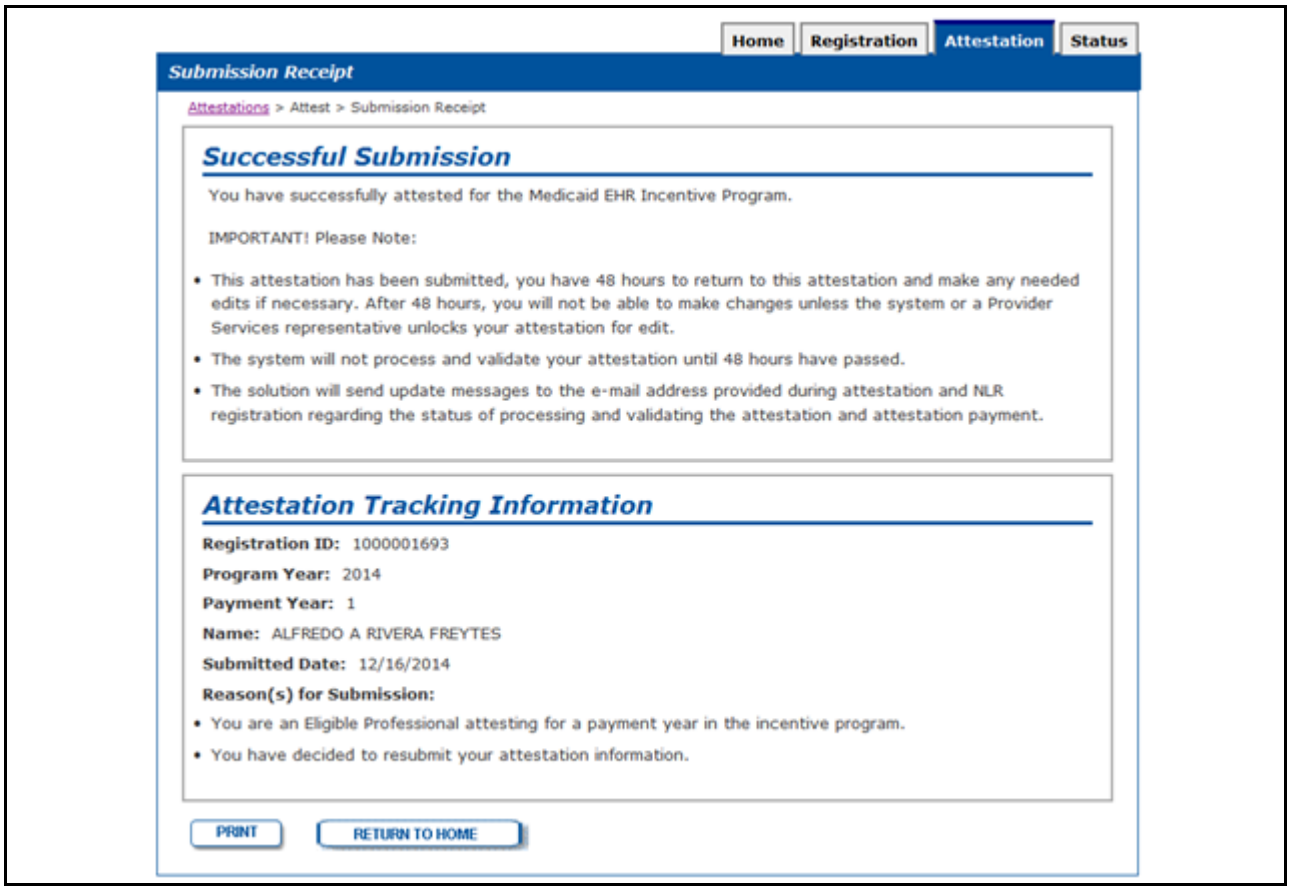

Home
Registration
Attestation
Status
Submission Receipt
Attestations > Attest > Submission Receipt
Successful Submission
You have successfully attested for the Medicaid EHR Incentive Program.
IMPORTANT! Please Note:
This attestation has been submitted, you have 48 hours to return to this attestation and make any needed edits if necessary. After 48 hours, you will not be able to make changes unless the system or a Provider Services representative unlocks your attestation for edit.
The system will not process and validate your attestation until 48 hours have passed.
The solution will send update messages to the e-mail address provided during attestation and NLR registration regarding the status of processing and validating the attestation and attestation payment.
Attestation Tracking Information
Registration ID: 1000001693
Program Year: 2014
Payment Year: 1
Name: ALFREDO A RIVERA FREYTES
Submitted Date: 12/16/2014
Reason(s) for Submission:
You are an Eligible Professional attesting for a payment year in the incentive program.
You have decided to resubmit your attestation information.
PRINT
RETURN TO HOME

Figure 56 - Submit Attestation - Submission Receipt Page

Upon the successful submission of the uploaded documents, the attestation entry process is completed. The USVI Medicaid EHR Incentive Program provides 48 hours to make changes. If

changes are made during the initial 48 hour period, a new 48 hour period will begin. Once no changes are made to an attestation for 48 hours, the USVI Medicaid EHR Incentive Program Attestation Application will execute its final eligibility checks. These include validating that the Medicaid counts entered by the EP are within a reasonable range of the fee-for-service stored in the USVI MMIS and querying the CMS NLR to determine if the attesting EP has already received an EHR Incentive Program payment from the Medicare EHR Incentive Program or another state's Medicaid EHR Incentive Program. This processing will take some time to complete, and payments will not be sent immediately after submitting a completed attestation.

After the eligibility and payment checks are executed, the USVI Medicaid EHR Incentive Program will send the EP an e-mail with their current attestation status. If an eligibility or payment error has occurred during the initial data verification process and assistance is needed, please contact the USVI Medicaid Provider Services Help Desk at 855-248-7536 option 2.

The USVI Medicaid EHR Incentive Program Attestation Application will describe the attestation errors. Alternatively, EPs can log in to the application and select the "Status" tab to display their current attestation status.

13. Status Grid

The table lists the attestation status that may occur.

Provider Screen Status	Admin Portal Attestation Status	Description - Provider
Attestation Not Allowed	Attestation Not Allowed	Provider's registration did not pass the inital eligibility check.
Attestation Not Started	Attestation Not Started	Provider's registration has processed successful; but the provider has not yet logged into the PIP solution and begun their attestation
Attestation In Progress	Attestation In Progress	Provider has opened their attestation and is actively editing it.
Submitted	Submitted	This status appears after submission for 48 hrs till final provider eligibility check is run. Provider can cancel an attestation and re-edit it for 2 days after submission prior to it being "finalized"
Pended	Pended	Provider sees "Pended"
Provider has failed final Elg check • POS Error • Volume error • Pay hold error	Resubmit	Provider sees "Resubmit" and the appropriate reason message for the eligibility error
Accepted	Accepted	Provider will see their attestation on the Status tab. The status will be Accepted
• Locked for Payment • Excluded from payment	Locked For Payment Excluded From Payment	Attestation remains on the Status tab only. Waiting for payment validation from NLR

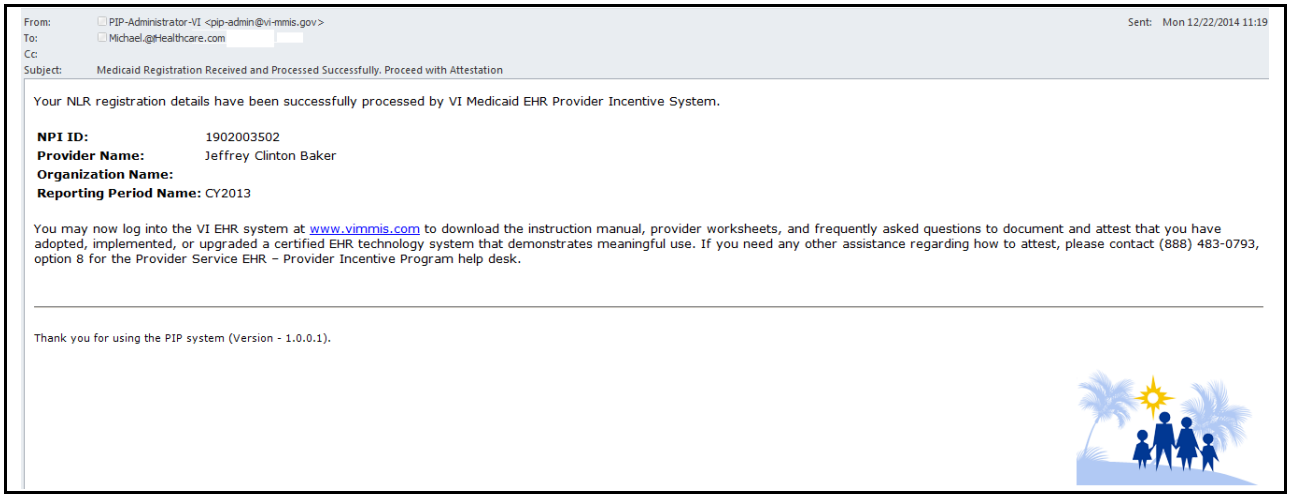
Figure 57 - Attestation Status Grid

14. Successful Registration with CMS Email

After registering with CMS, it may take 48 hours before this message is received.

- The delay is for CMS processing registration and sending them to the appropriate State repository. The Provider Portal application will receive the registration in the State repository and process registration. The Provider Portal application checks that the provider is a valid provider type and has active enrollment in Medicaid.

When this message is received, log into the Provider Portal to register and attest.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.@Healthcare.com
Cc:
Subject: Medicaid Registration Received and Processed Successfully. Proceed with Attestation
Sent: Mon 12/22/2014 11:19

Your NLR registration details have been successfully processed by VI Medicaid EHR Provider Incentive System.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013

You may now log into the VI EHR system at www.vimmis.com to download the instruction manual, provider worksheets, and frequently asked questions to document and attest that you have adopted, implemented, or upgraded a certified EHR technology system that demonstrates meaningful use. If you need any other assistance regarding how to attest, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 58 - Email - Ready to attest

15. Submitted Attestation Email

This email is sent after submitting the attestation. The Attestation Application will allow EPs to make changes to a submitted attestation for 48 hours. After 48 hours have passed from the last attestation change, the system will execute its final edits.

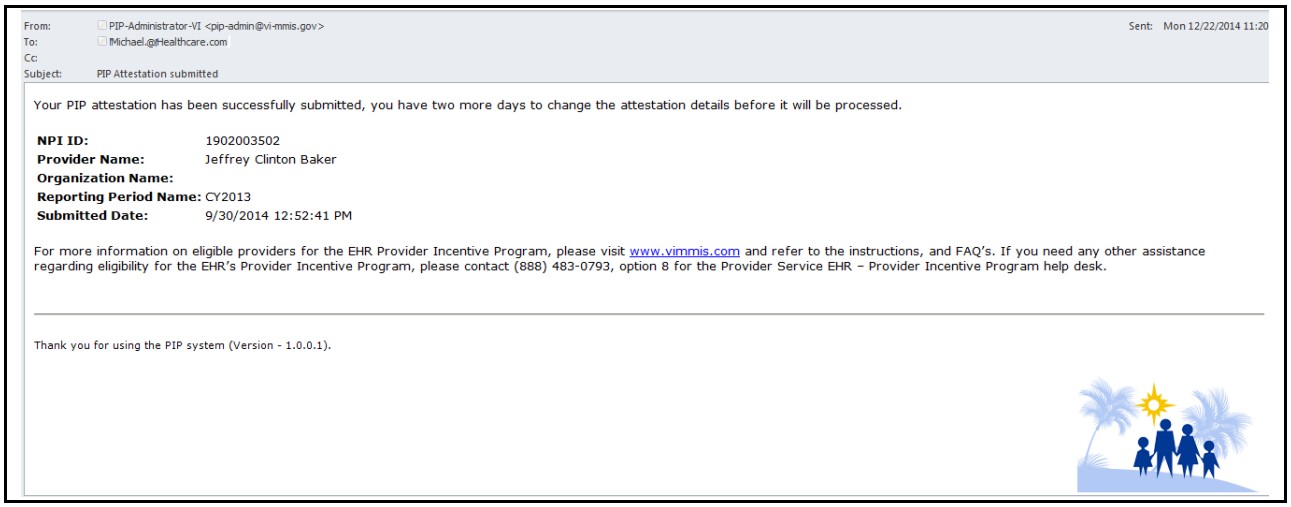
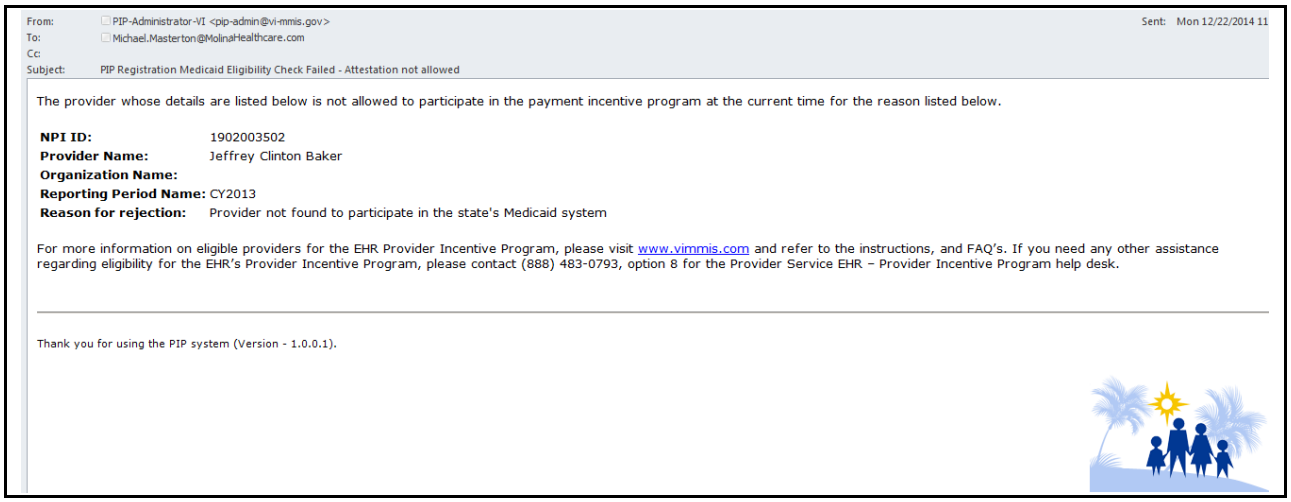

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:20
To: Michael.@Healthcare.com
Cc:
Subject: PIP Attestation submitted
Your PIP attestation has been successfully submitted, you have two more days to change the attestation details before it will be processed.
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.
Thank you for using the PIP system (Version - 1.0.0.1).

Figure 59 - Email - Submitted Attestation

16. Error occurred when processing registration Email

When the Attestation Application receives a registration from the National Level Repository (NLR), it must validate the EP's Medicaid EHR Incentive Program eligibility. The email below is sent if the EP does not exist in the MMIS.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed

The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Reason for rejection: Provider not found to participate in the state's Medicaid system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 60 - Email - Error Processing Registration

17. Attestation Accepted Email

This email is sent when the 48 hours allowed for attestation changes have expired. The attestation is no longer accessible for changes within the application. The attestation details will be sent to the NLR to check if any other EHR Incentive Program payments have been made for the attesting EP for the given payment year.

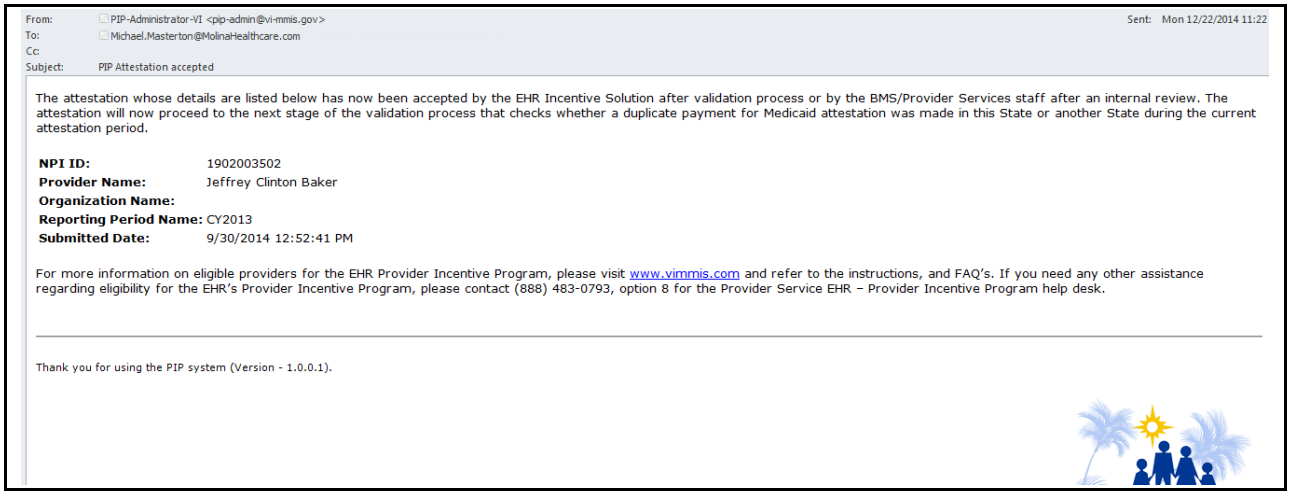

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:22
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation accepted
The attestation whose details are listed below has now been accepted by the EHR Incentive Solution after validation process or by the BMS/Provider Services staff after an internal review. The attestation will now proceed to the next stage of the validation process that checks whether a duplicate payment for Medicaid attestation was made in this State or another State during the current attestation period.
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.
Thank you for using the PIP system (Version - 1.0.0.1).

Figure 61 - Email - Accepted Attestation

18. Error Occurred While Processing Registration – Medicaid Enrollment failed Email

The following checks are made when an attestation is received from the NLR. The email below displays all the possible error messages for the following checks.

1. Check if the provider is enrolled in Medicaid program during the attestation period.
2. Check if the provider type that was selected when registering on the CMS site matches the provider type on the provider's enrollment record.
3. Check if the payee NPI entered when registering on the CMS site is found when validating the attesting provider's payees on the Medicaid record.

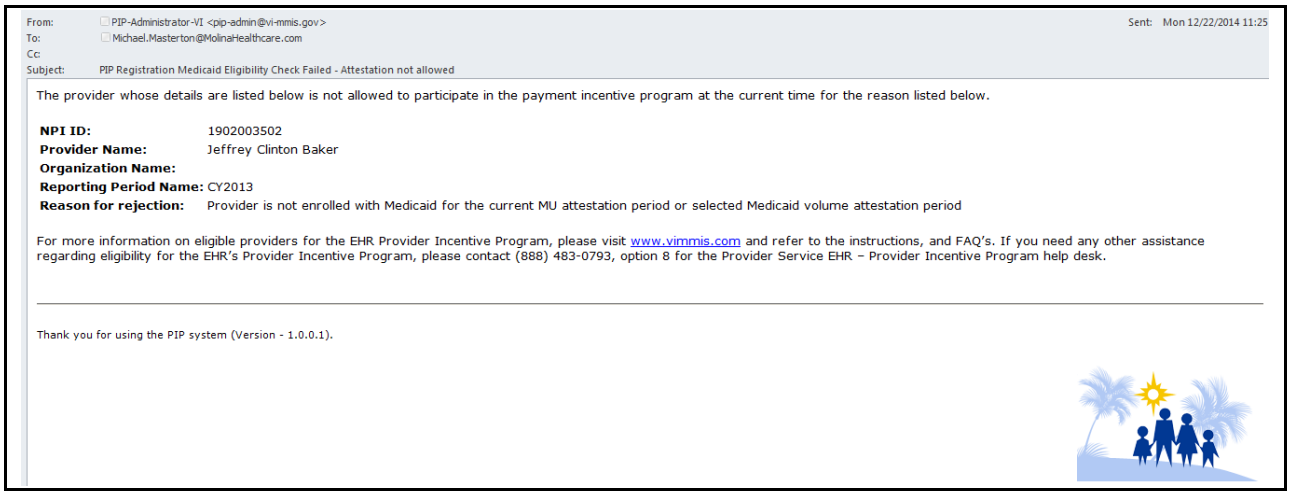
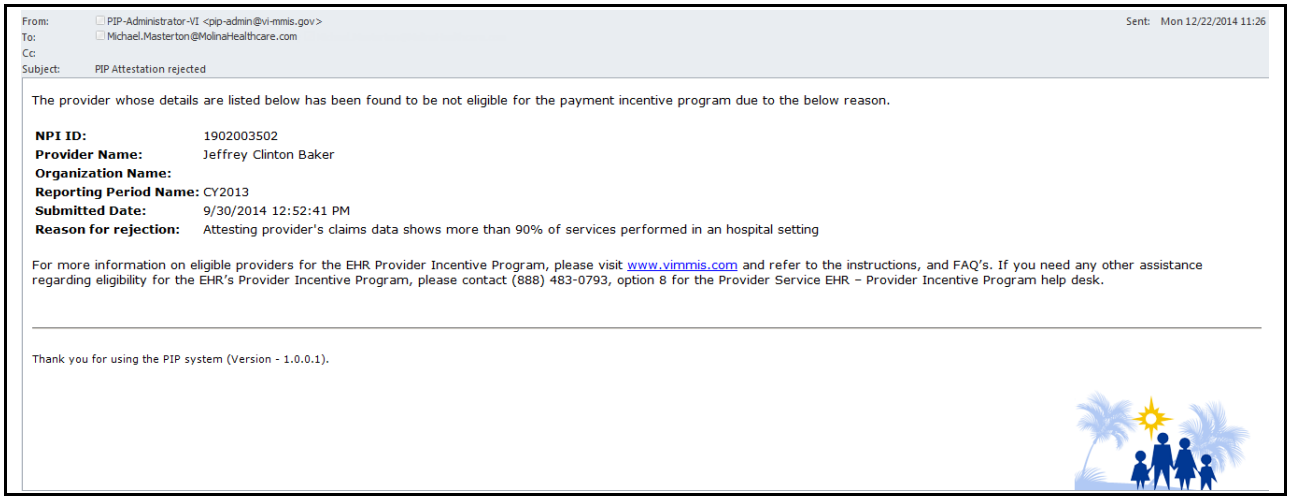

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:25
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed
The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Reason for rejection: Provider is not enrolled with Medicaid for the current MU attestation period or selected Medicaid volume attestation period
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.
Thank you for using the PIP system (Version - 1.0.0.1).

Figure 62 - Email - Enrollment Failed

19. Attestation Error – Practice predominately in a Hospital Setting Email

Claims checks are part of the processing. If it was found that the provider practiced predominately in a hospital, the attestation is ineligible and the email is sent.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected
Sent: Mon 12/22/2014 11:26

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Attesting provider's claims data shows more than 90% of services performed in an hospital setting

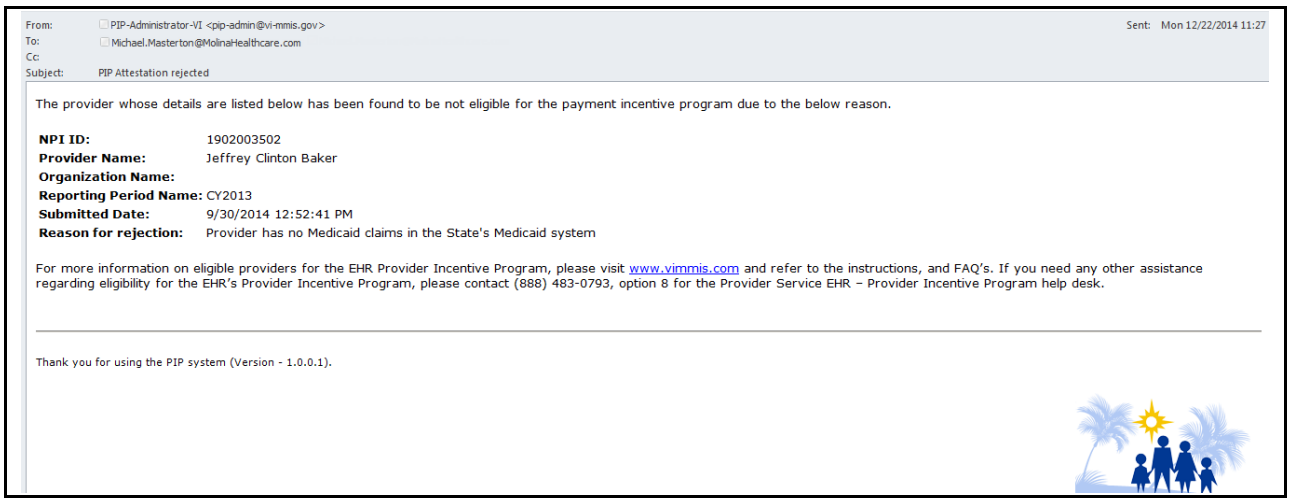
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 63 - Email – Volume indicates practice in Hospital

20. Attestation Error – Medicaid Claims count failed Email

The solution will check the provider's Medicaid claims that were submitted during the attestation period. If there were no claims found for the attestation period, the following email will be sent.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected
Sent: Mon 12/22/2014 11:27

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

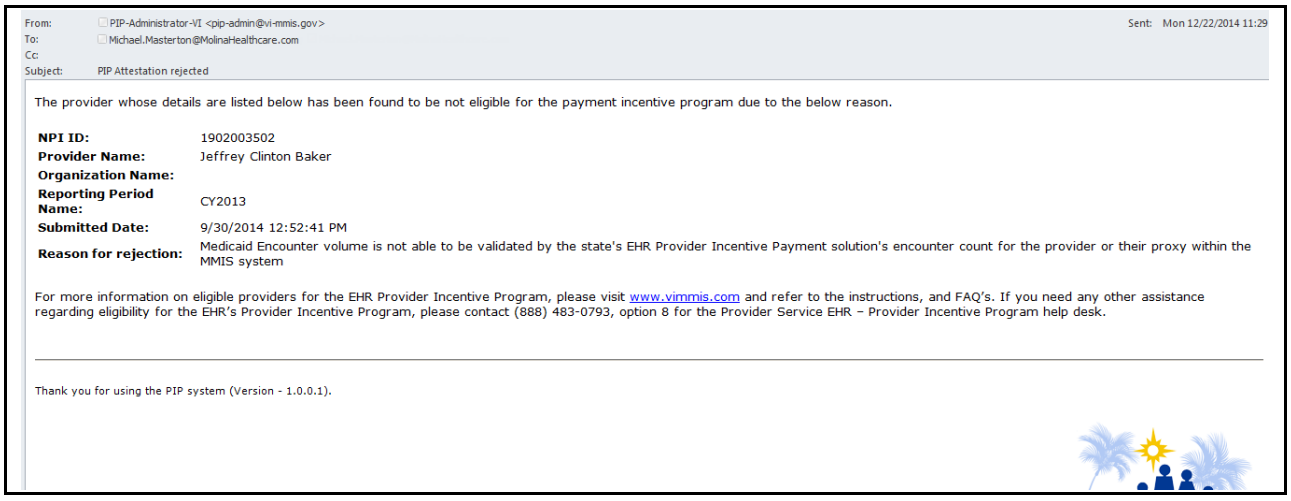
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Provider has no Medicaid claims in the State's Medicaid system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 64 - Email - Medicaid Claims not found

If the solution found that claims counts could not be validated, then the following email is sent.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected
Sent: Mon 12/22/2014 11:29

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Medicaid Encounter volume is not able to be validated by the state's EHR Provider Incentive Payment solution's encounter count for the provider or their proxy within the MMIS system

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 65 - Email - Cannot validate Medicaid Claims

21. Attestation Paid Email

If final eligibility checks pass and no payment issues occurred, an email is sent indicating that payment is approved and being processed. The payment will continue with additional processing, so payment arrival will take a few days.

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: Your VI EHR Incentive payment has been created - Attestation Paid
Sent: Mon 12/22/2014 11:29

The attestation whose details are listed below has been paid.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Attestation Submitted Date: 9/30/2014 12:52:41 PM
Amount Paid: $8,500.00
Payment Date: 9/30/2014 12:53:52 PM

For more information on payment or eligibility for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding payment or eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 66 - Email - Attestation Paid

22. Attestation Payment Denied Email

If final eligibility checks did not pass and payment issues occurred, an email indicating denial is sent. The USVI Medicaid Provider Services staff at 855-248-7536 option 2 may be able to address questions.

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov> Sent: Mon 12/22/2014 11:29
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: Your VI EHR Incentive payment has been created - Attestation Paid

The attestation whose details are listed below has been paid.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Attestation Submitted Date: 9/30/2014 12:52:41 PM
Amount Paid: $8,500.00
Payment Date: 9/30/2014 12:53:52 PM

For more information on payment or eligibility for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding payment or eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 67 - Email - Attestation payment denied

23. Attestation Payment Denied – Pay Hold found

Payment is denied if the provider is on pay hold and this email is sent if it is found.

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:30
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected

The provider whose details are listed below has been found to be not eligible for the payment incentive program due to the below reason.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for rejection: Provider is on a pay hold and not eligible for payment at this time

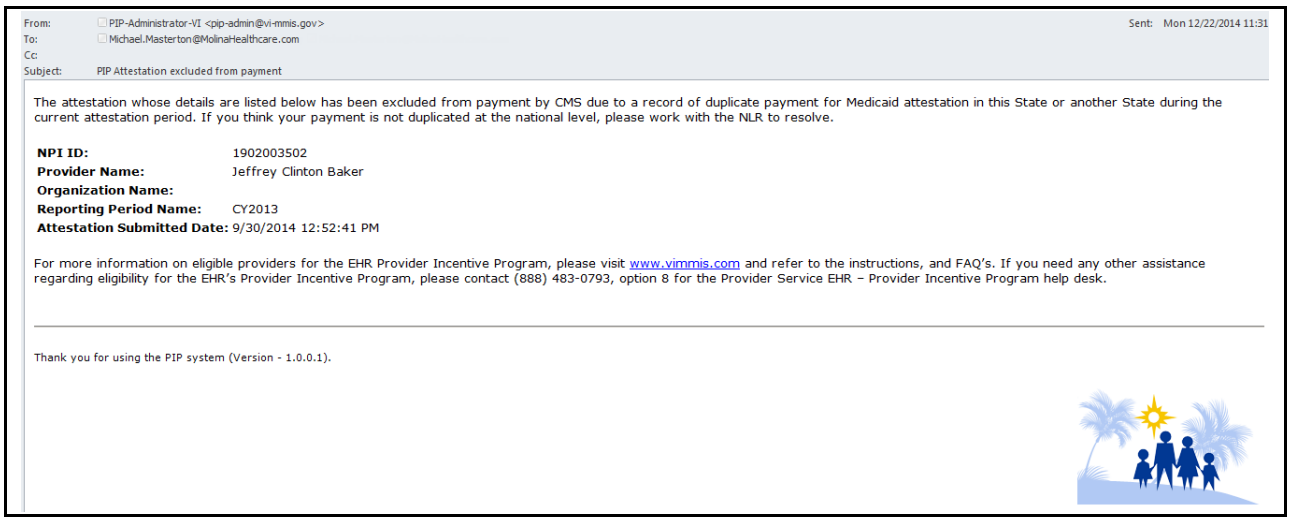
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 68 - Email - Attestation Payment denied, pay hold found

24. Attestation excluded from Payment Email

This email indicates that CMS has already has a payment on record from this provider. Please contact the CMS NLR for questions and concerns.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:31
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation excluded from payment

The attestation whose details are listed below has been excluded from payment by CMS due to a record of duplicate payment for Medicaid attestation in this State or another State during the current attestation period. If you think your payment is not duplicated at the national level, please work with the NLR to resolve.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Attestation Submitted Date: 9/30/2014 12:52:41 PM

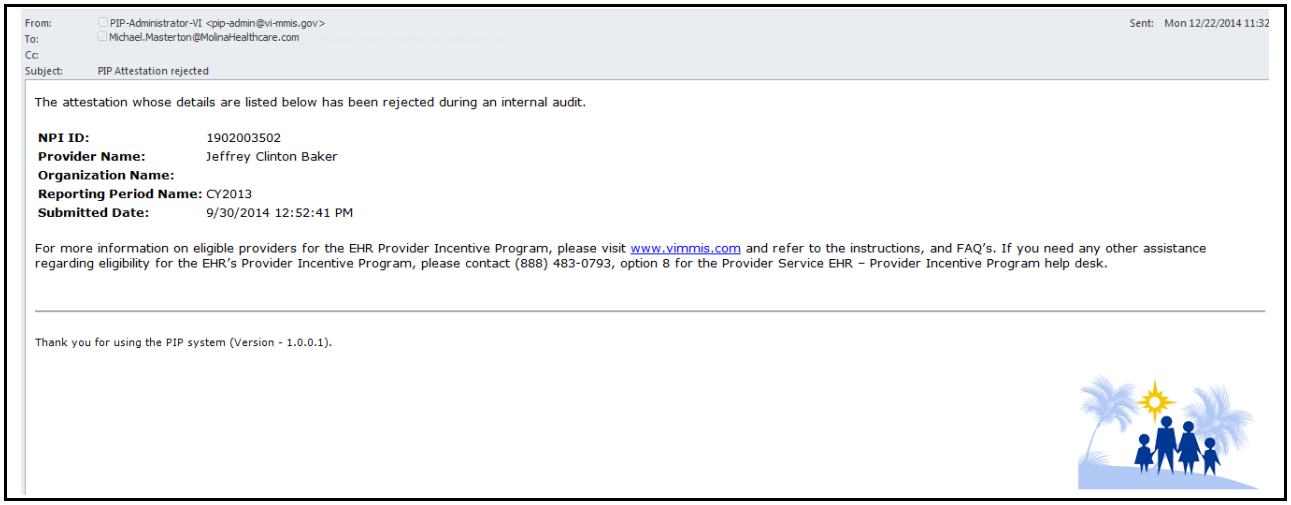
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 69 - Email - Attestation payment denied, Duplicate payment found

25. Attestation Rejected Email

USVI Medicaid and USVI Medicaid Provider Services staff has the ability to review attestation and reject a submitted attestation. When the attestation is rejected, an email is sent to notify the user of the status change. To find out more information, please contact the USVI Medicaid Provider Services staff at 855-248-7536 option 2.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation rejected
Sent: Mon 12/22/2014 11:32

The attestation whose details are listed below has been rejected during an internal audit.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM

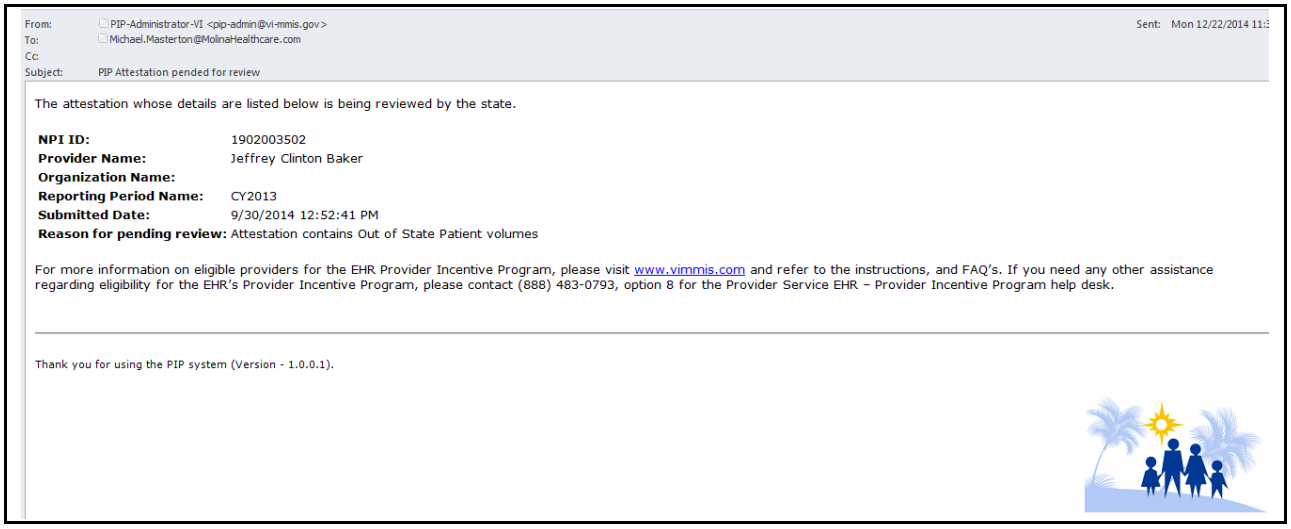
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 70 - Email - Attestation rejected

26. Attestation Pended for Out of State Entries

If a submitted attestation has passed volume checks and has out of state entries, the attestation will be pended. The USVI Medicaid and USVI Medicaid Provider Services staff will review the required documentation and determine if the attestation is acceptable or not. The following email indicates that the attestation was "Pended". To find out more information, please contact the USVI Medicaid Provider Services staff at 855-248-7536 option 2.



From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Attestation pended for review
Sent: Mon 12/22/2014 11:

The attestation whose details are listed below is being reviewed by the state.

NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Submitted Date: 9/30/2014 12:52:41 PM
Reason for pending review: Attestation contains Out of State Patient volumes

For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.

Thank you for using the PIP system (Version - 1.0.0.1).

Figure 71 - Email - Attestation pended for validation of out-of-state entries

27. Attestation Failed Meaningful Use

If a submitted attestation did not pass the meaningful use questions, the email is sent to inform the EP.

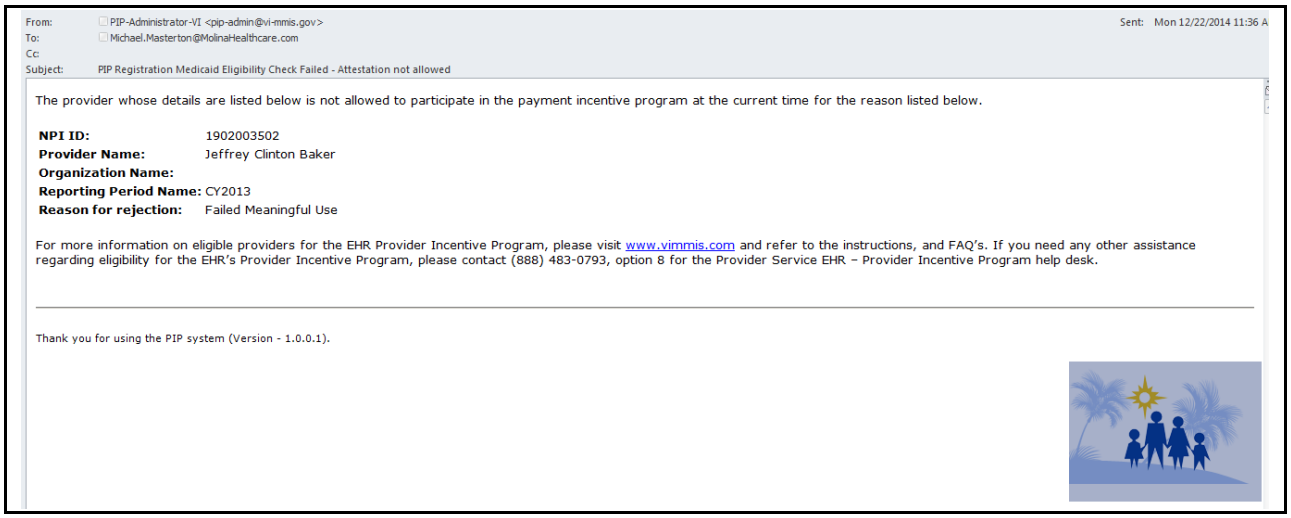
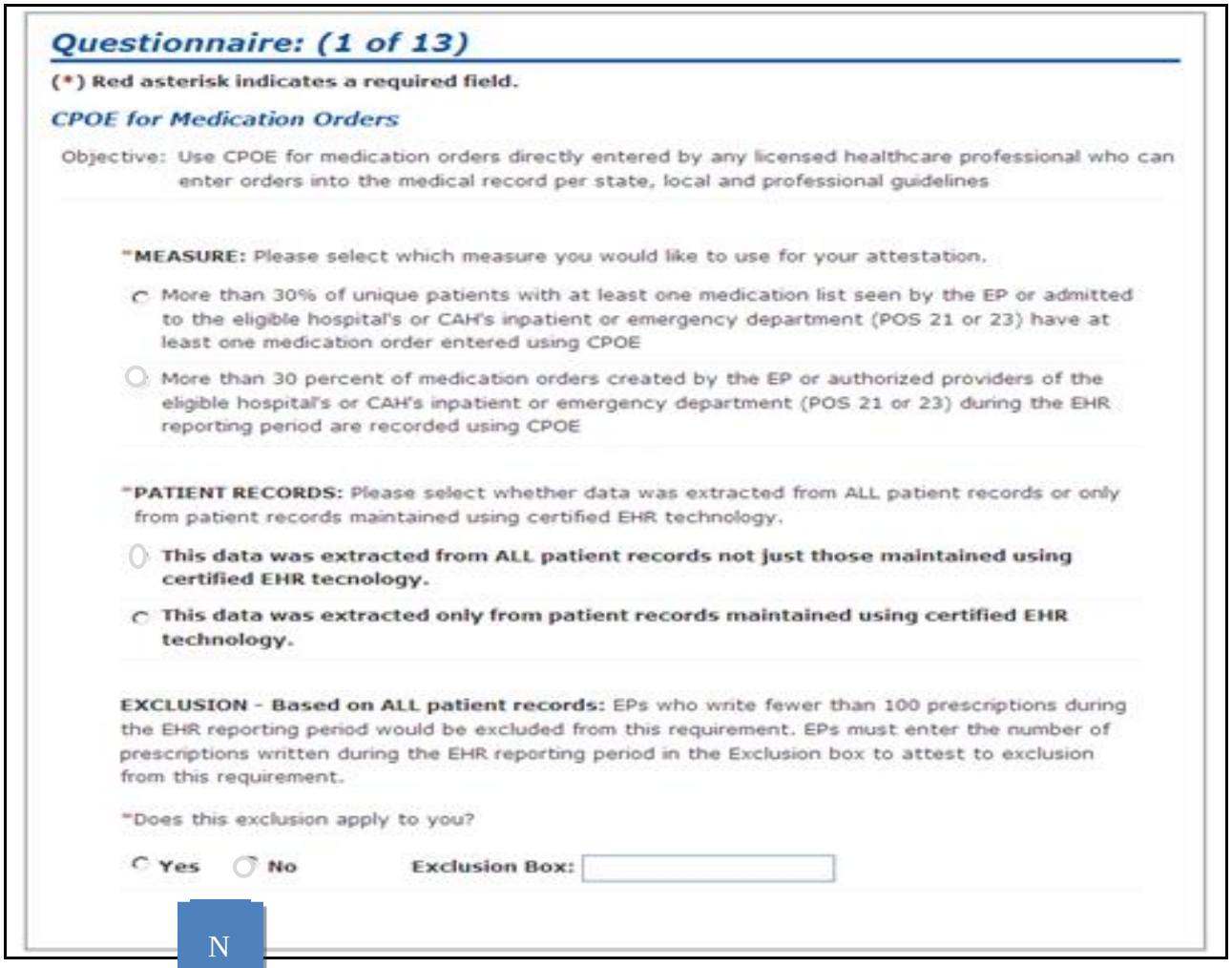

From: PIP-Administrator-VI <pip-admin@vi-mmis.gov>
Sent: Mon 12/22/2014 11:36 A
To: Michael.Masterton@MolinaHealthcare.com
Cc:
Subject: PIP Registration Medicaid Eligibility Check Failed - Attestation not allowed
The provider whose details are listed below is not allowed to participate in the payment incentive program at the current time for the reason listed below.
NPI ID: 1902003502
Provider Name: Jeffrey Clinton Baker
Organization Name:
Reporting Period Name: CY2013
Reason for rejection: Failed Meaningful Use
For more information on eligible providers for the EHR Provider Incentive Program, please visit www.vimmis.com and refer to the instructions, and FAQ's. If you need any other assistance regarding eligibility for the EHR's Provider Incentive Program, please contact (888) 483-0793, option 8 for the Provider Service EHR – Provider Incentive Program help desk.
Thank you for using the PIP system (Version - 1.0.0.1).

Figure 72 - Email - Attestation failed meaningful use

28. 2013 ONLY Meaningful Use Core Measures Screen Shots



Questionnaire: (1 of 13)

(*) Red asterisk indicates a required field.

CPOE for Medication Orders

Objective: Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines

*MEASURE: Please select which measure you would like to use for your attestation.

- More than 30% of unique patients with at least one medication list seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one medication order entered using CPOE
- More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE

*PATIENT RECORDS: Please select whether data was extracted from ALL patient records or only from patient records maintained using certified EHR technology.

- **This data was extracted from ALL patient records not just those maintained using certified EHR tecnology.**
- **This data was extracted only from patient records maintained using certified EHR technology.**

EXCLUSION - Based on ALL patient records: EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.

*Does this exclusion apply to you?

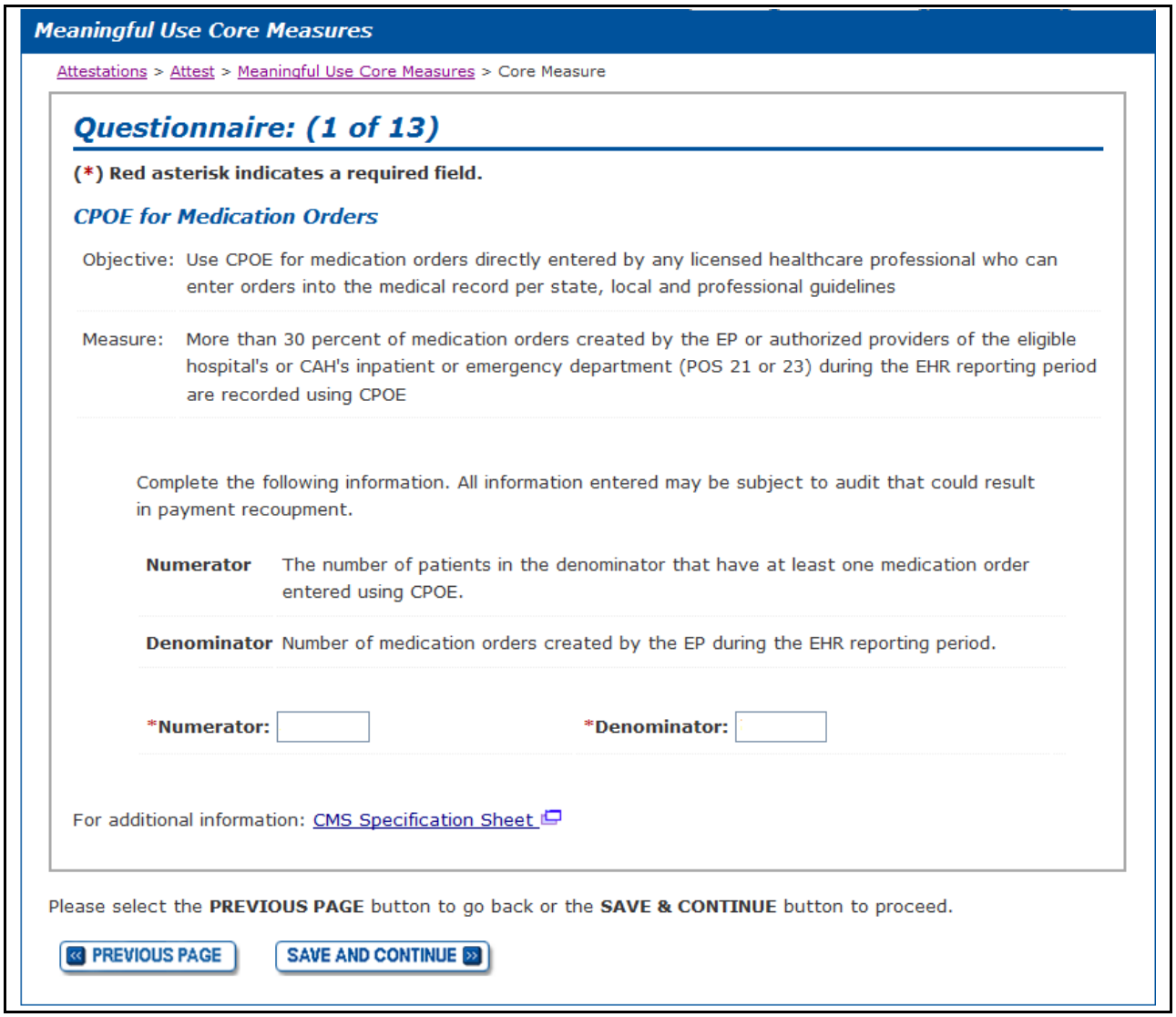
Yes No Exclusion Box:

NO

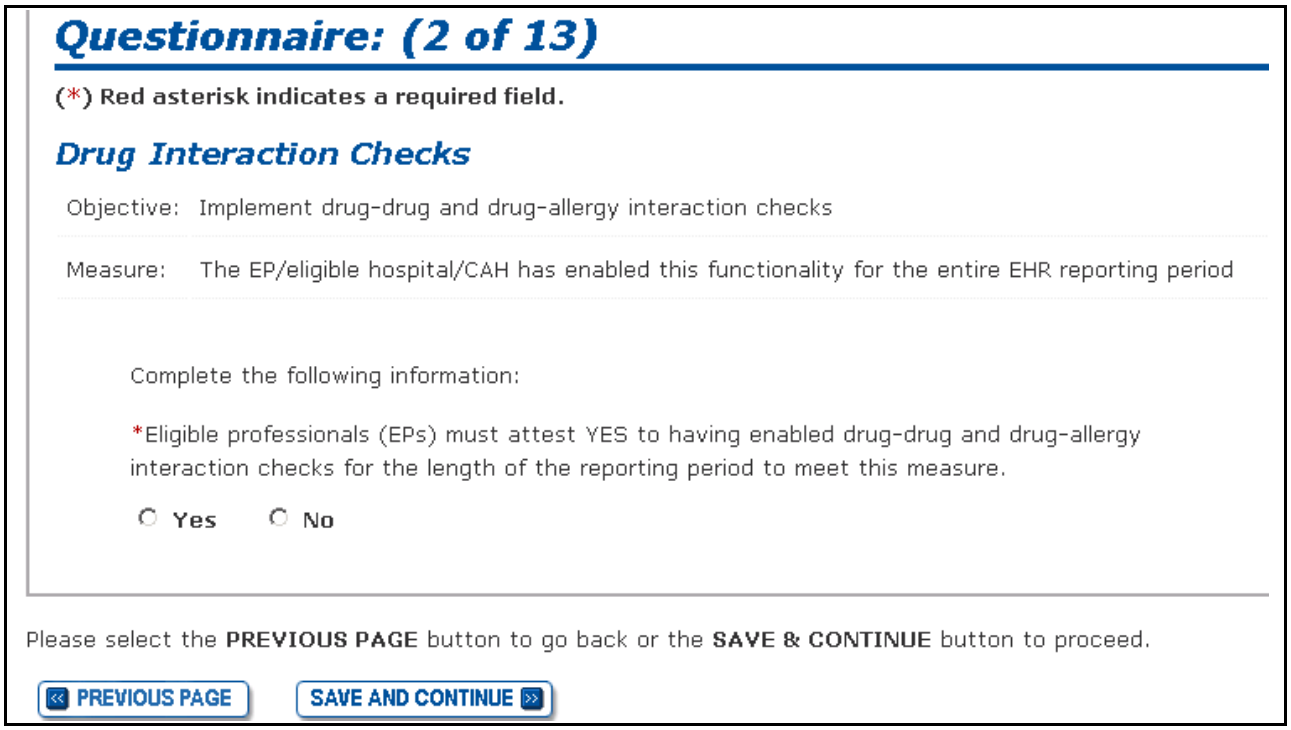
lease select th **OUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PA SAVE AND CONTINUE

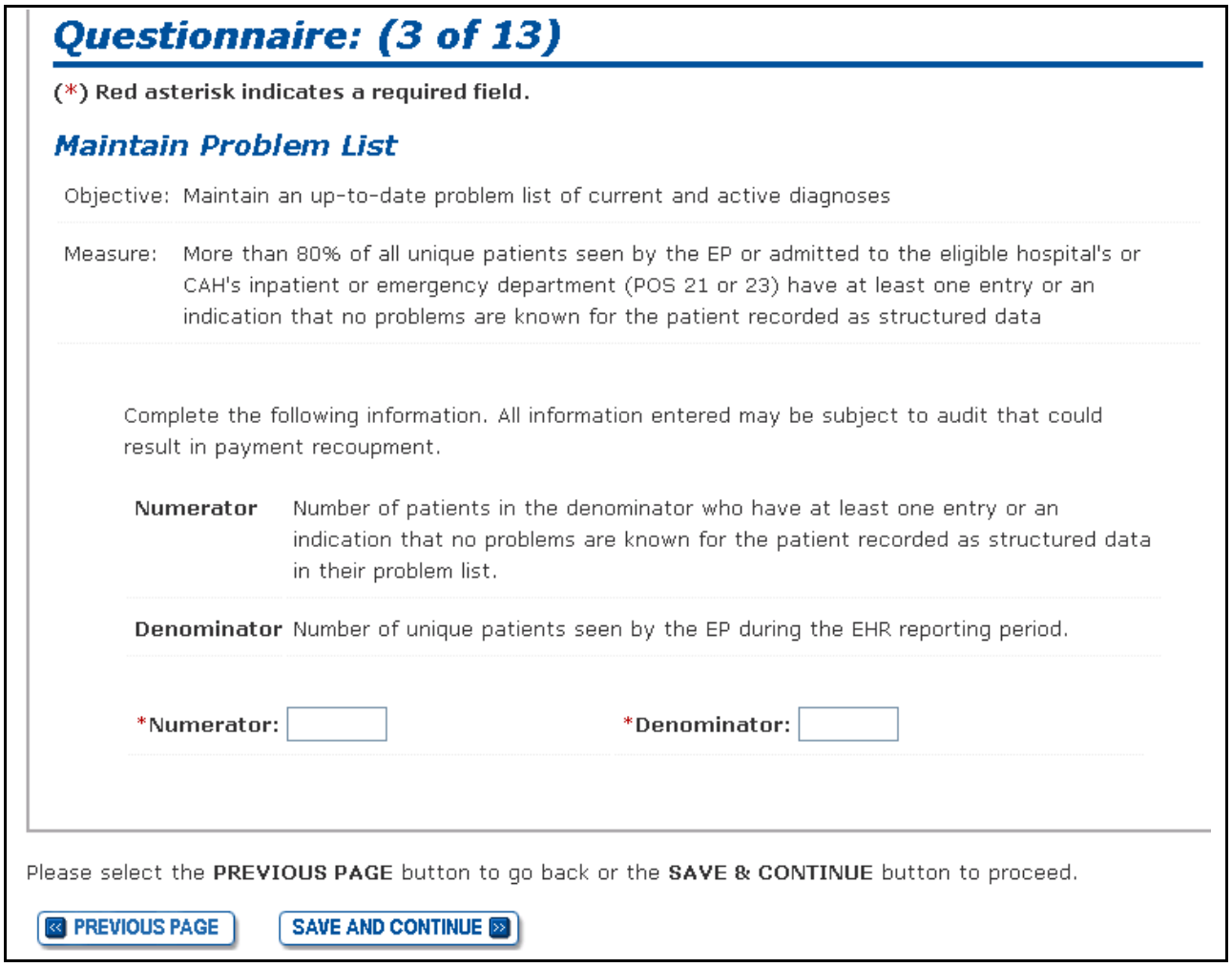
Meaningful Use Core Question 1 – CPOE for Medication Orders


Meaningful Use Core Measures
Attestations > Attest > Meaningful Use Core Measures > Core Measure
Questionnaire: (1 of 13)
(*) Red asterisk indicates a required field.
CPOE for Medication Orders
Objective: Use CPOE for medication orders directly entered by any licensed healthcare professional who can enter orders into the medical record per state, local and professional guidelines
Measure: More than 30 percent of medication orders created by the EP or authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator The number of patients in the denominator that have at least one medication order entered using CPOE.
Denominator Number of medication orders created by the EP during the EHR reporting period.
*Numerator:
*Denominator:
For additional information: CMS Specification Sheet
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

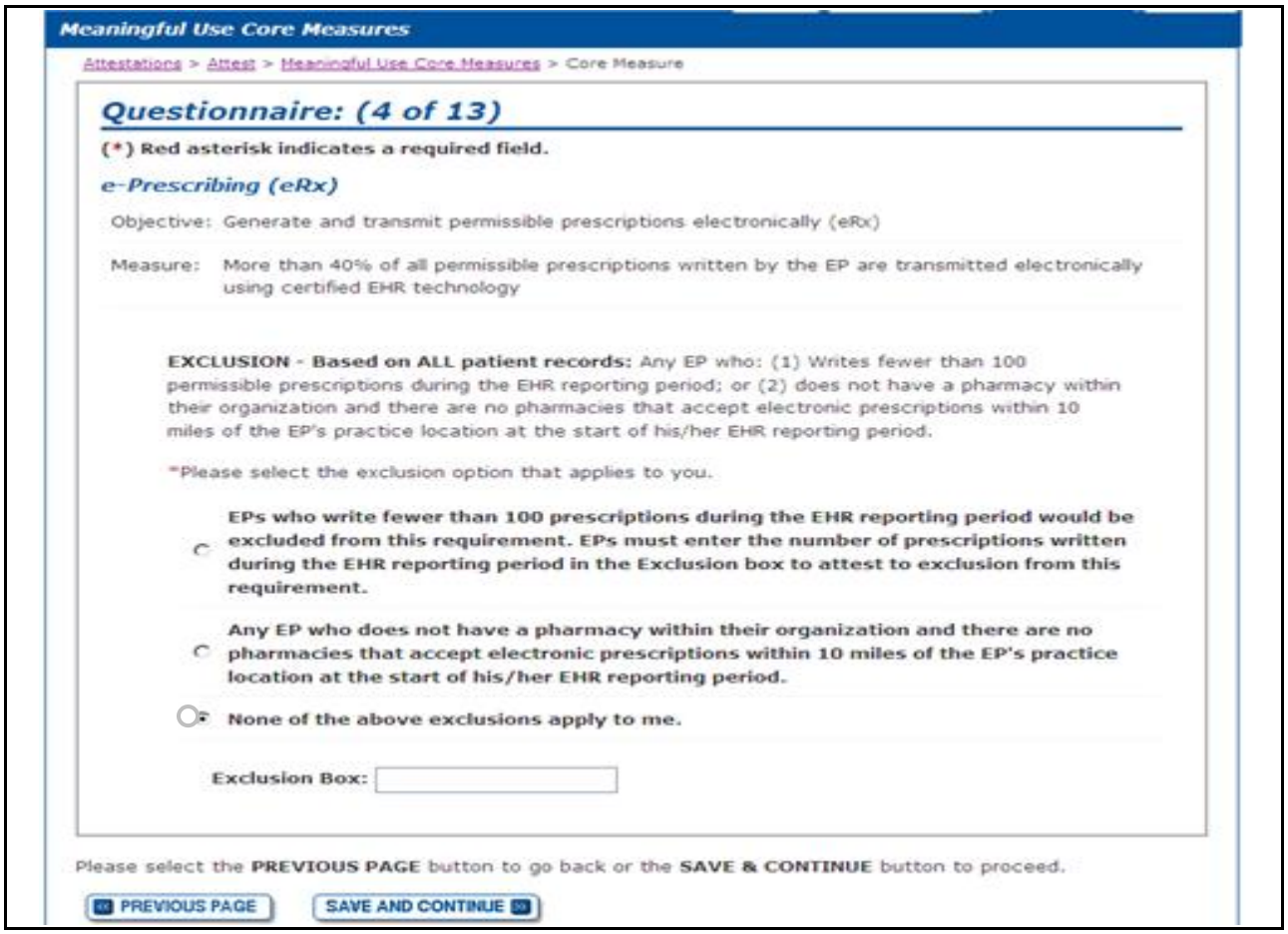
Meaningful Use Core Question 1 – CPOE for Medication Orders if exclusion does not apply


Questionnaire: (2 of 13)
(*) Red asterisk indicates a required field.
Drug Interaction Checks
Objective: Implement drug-drug and drug-allergy interaction checks
Measure: The EP/eligible hospital/CAH has enabled this functionality for the entire EHR reporting period
Complete the following information:
*Eligible professionals (EPs) must attest YES to having enabled drug-drug and drug-allergy interaction checks for the length of the reporting period to meet this measure.
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

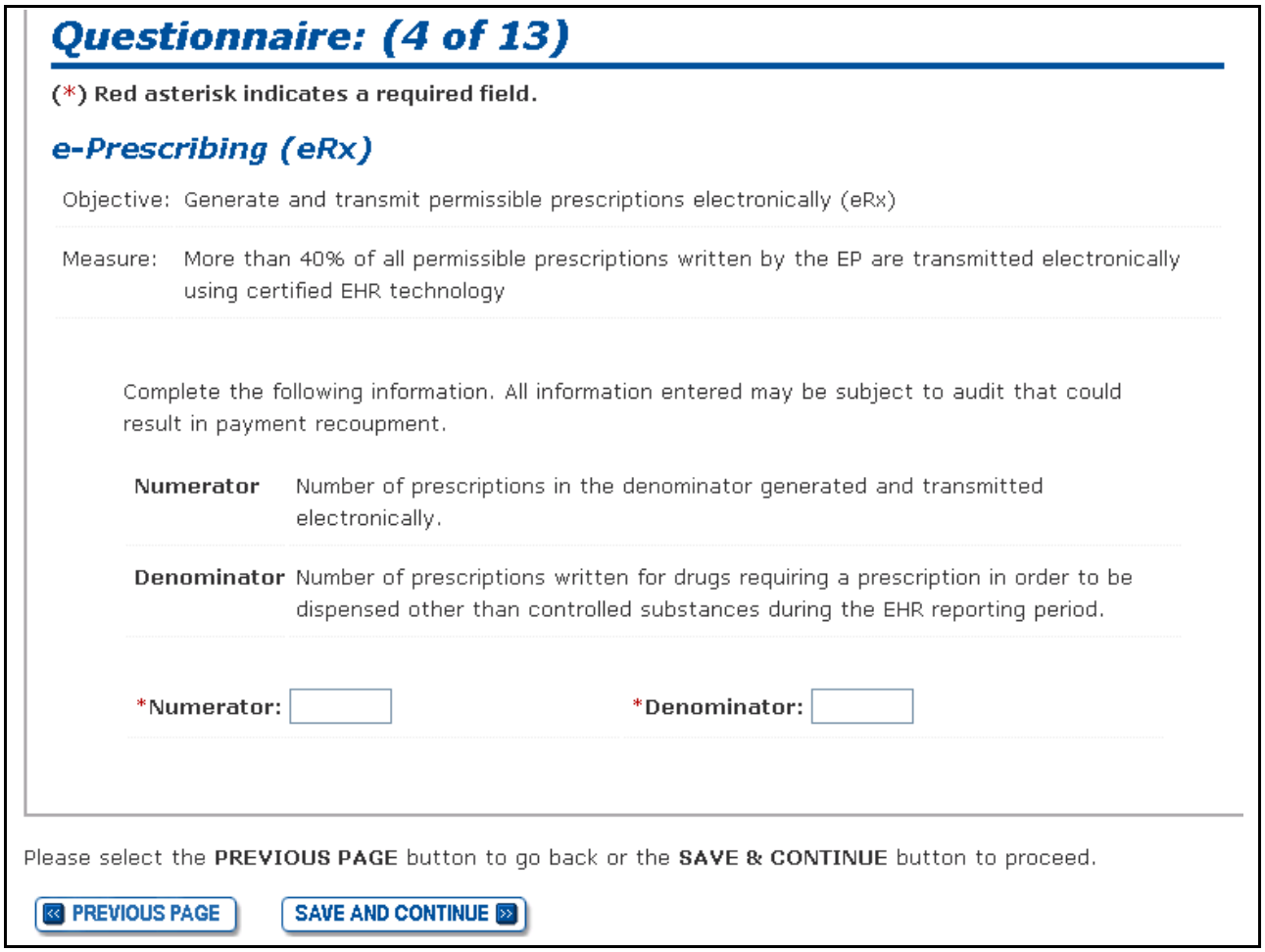
Meaningful Use Core Measure Question 2 – Drug Interaction Checks


Questionnaire: (3 of 13)
(*) Red asterisk indicates a required field.
Maintain Problem List
Objective: Maintain an up-to-date problem list of current and active diagnoses
Measure: More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry or an indication that no problems are known for the patient recorded as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator
Number of patients in the denominator who have at least one entry or an indication that no problems are known for the patient recorded as structured data in their problem list.
Denominator
Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

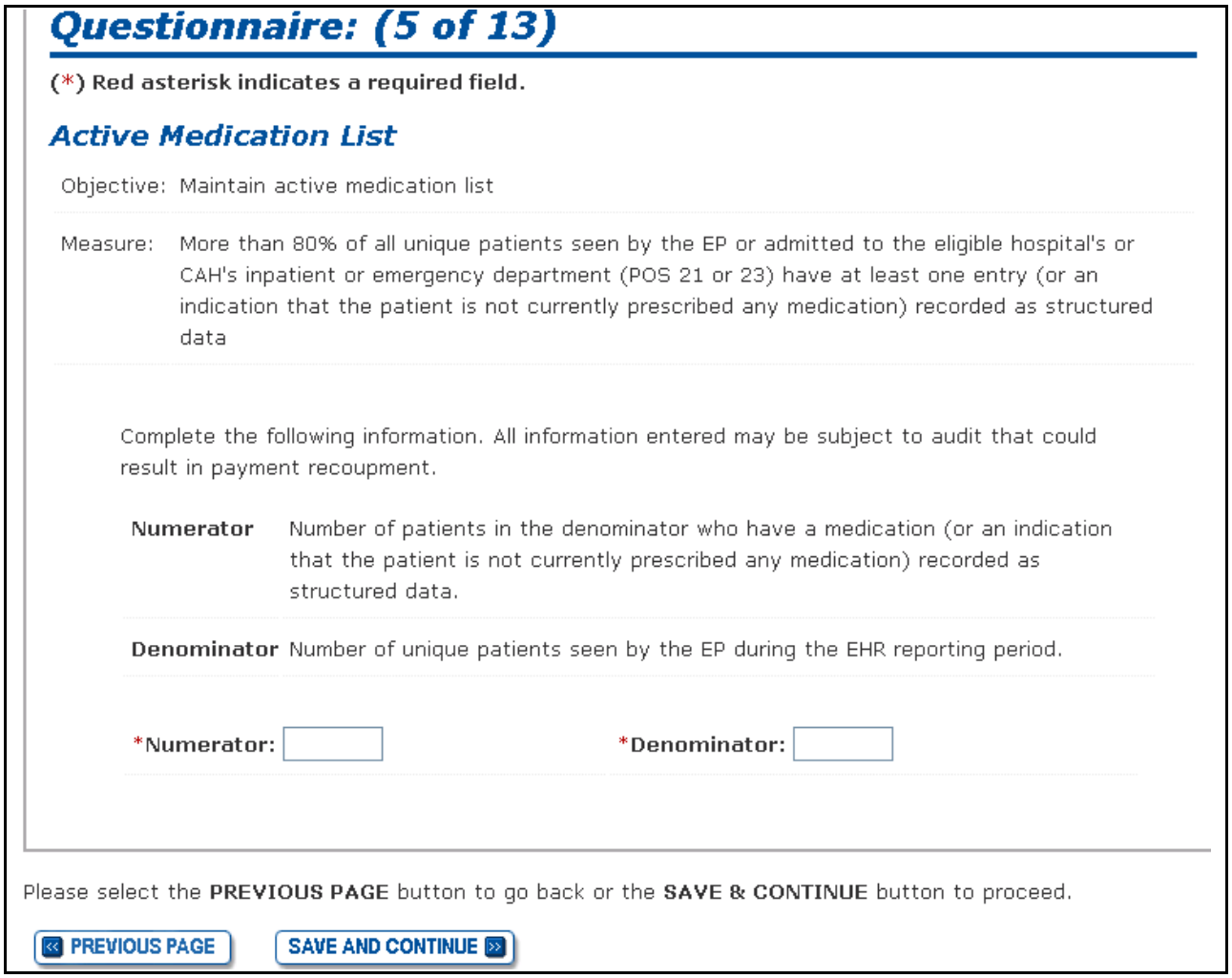
Meaningful Use Core Question 3 – Maintain Problem List


Meaningful Use Core Measures
Attestations > Attest > Meaningful Use Core Measures > Core Measure
Questionnaire: (4 of 13)
(*) Red asterisk indicates a required field.
e-Prescribing (eRx)
Objective: Generate and transmit permissible prescriptions electronically (eRx)
Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
EXCLUSION - Based on ALL patient records: Any EP who: (1) Writes fewer than 100 permissible prescriptions during the EHR reporting period; or (2) does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
*Please select the exclusion option that applies to you.
EPs who write fewer than 100 prescriptions during the EHR reporting period would be excluded from this requirement. EPs must enter the number of prescriptions written during the EHR reporting period in the Exclusion box to attest to exclusion from this requirement.
Any EP who does not have a pharmacy within their organization and there are no pharmacies that accept electronic prescriptions within 10 miles of the EP's practice location at the start of his/her EHR reporting period.
None of the above exclusions apply to me.
Exclusion Box:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

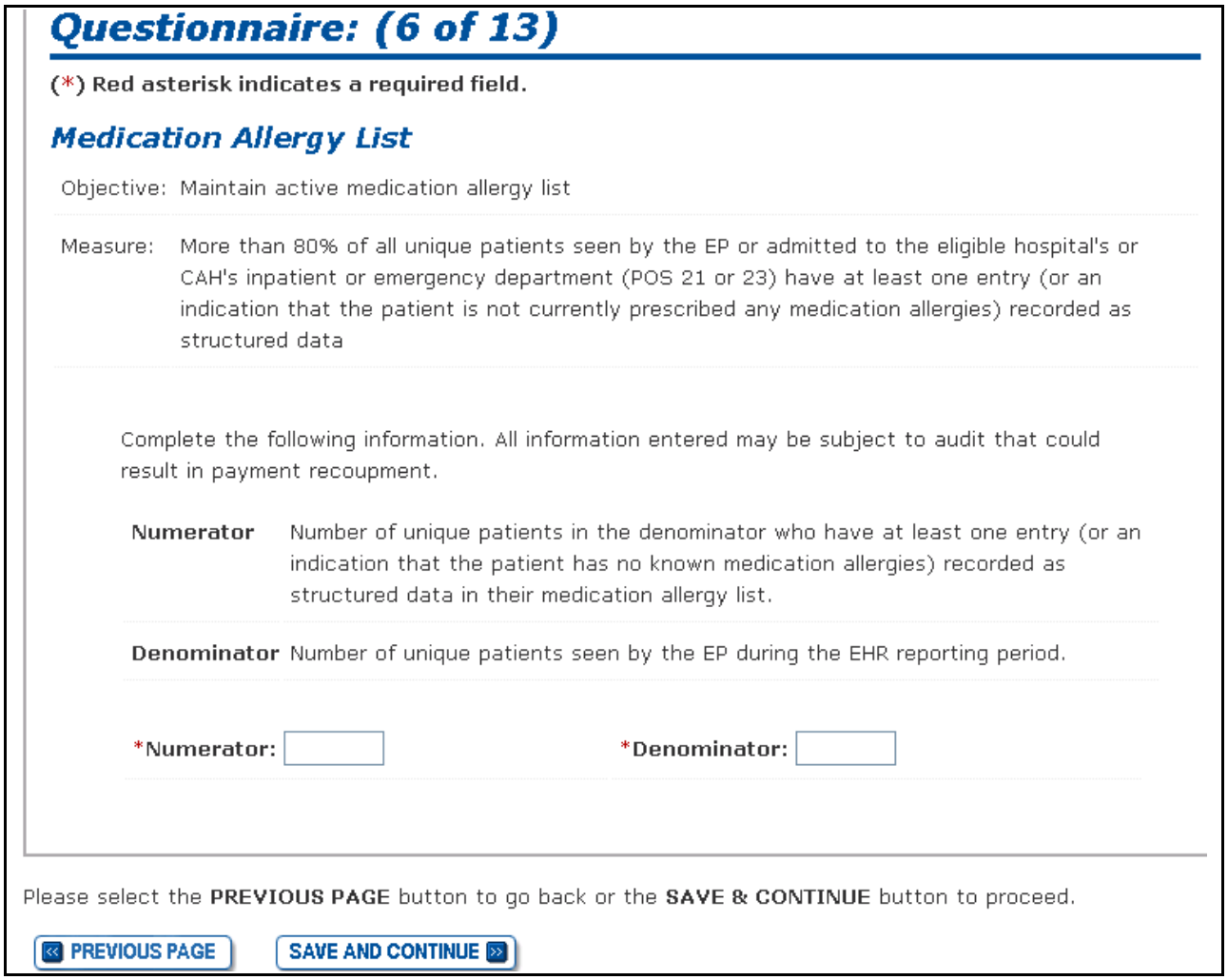
Meaningful Use Core Question 4 – e-Prescribing


Questionnaire: (4 of 13)
(*) Red asterisk indicates a required field.
e-Prescribing (eRx)
Objective: Generate and transmit permissible prescriptions electronically (eRx)
Measure: More than 40% of all permissible prescriptions written by the EP are transmitted electronically using certified EHR technology
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of prescriptions in the denominator generated and transmitted electronically.
Denominator Number of prescriptions written for drugs requiring a prescription in order to be dispensed other than controlled substances during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

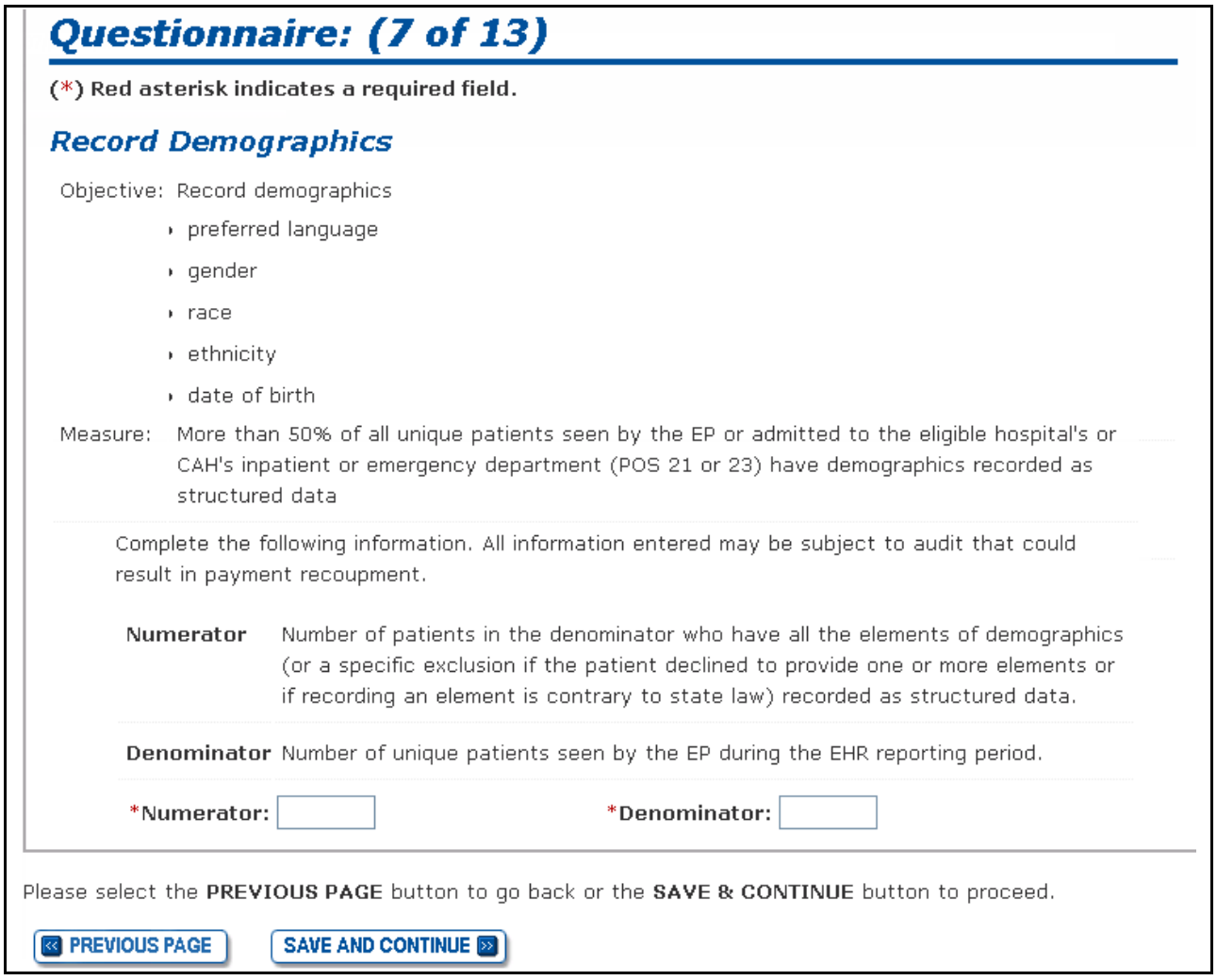
Meaningful Use Core Question 4 – answered No to exclusions


Questionnaire: (5 of 13)
(*) Red asterisk indicates a required field.
Active Medication List
Objective: Maintain active medication list
Measure: More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication) recorded as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who have a medication (or an indication that the patient is not currently prescribed any medication) recorded as structured data.
Denominator Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

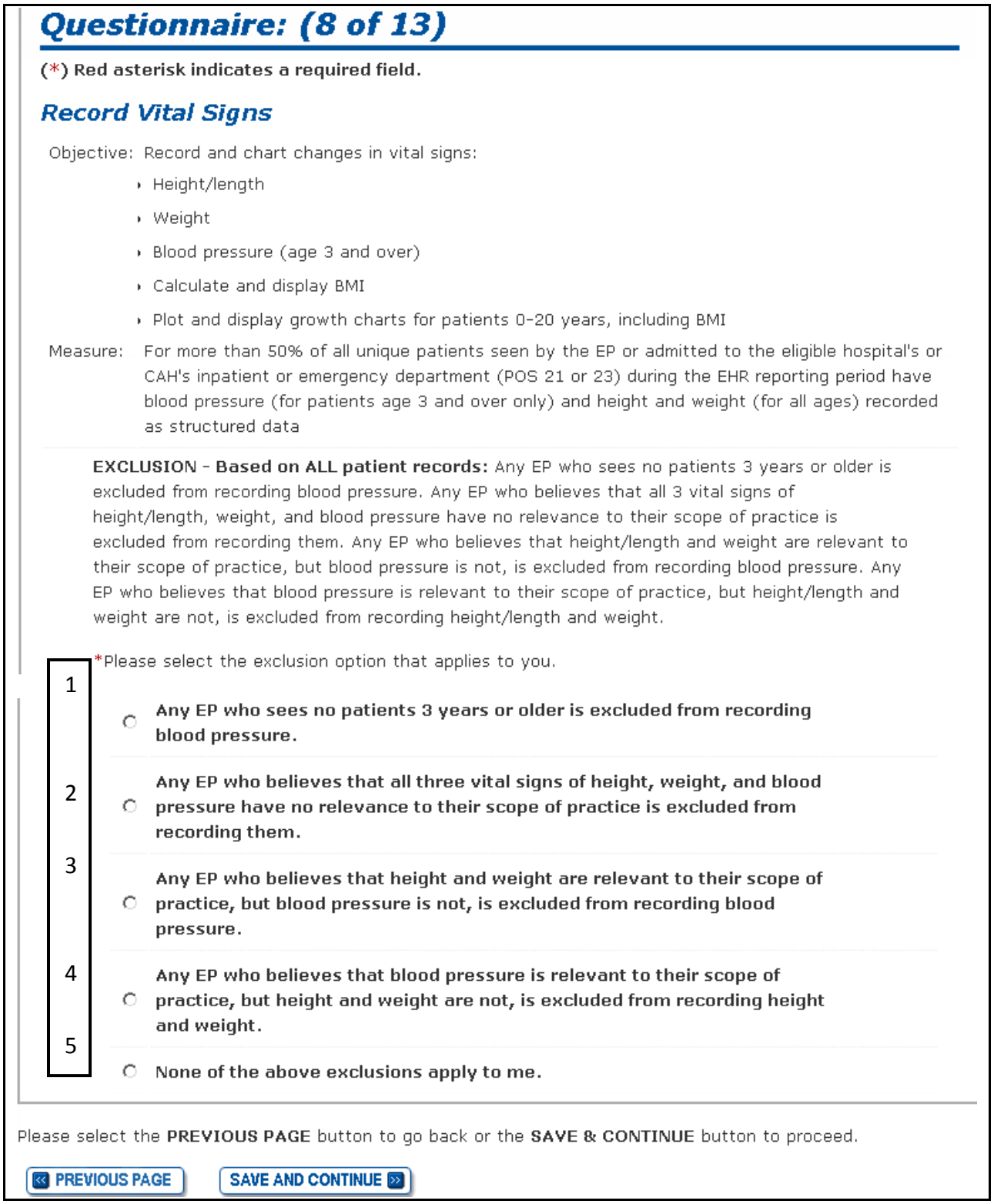
Meaningful Use Core Question 5 – Active Medication List


Questionnaire: (6 of 13)
(*) Red asterisk indicates a required field.
Medication Allergy List
Objective: Maintain active medication allergy list
Measure: More than 80% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have at least one entry (or an indication that the patient is not currently prescribed any medication allergies) recorded as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of unique patients in the denominator who have at least one entry (or an indication that the patient has no known medication allergies) recorded as structured data in their medication allergy list.
Denominator Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Meaningful Use Core Question 6 – Medication Allergy List


Questionnaire: (7 of 13)
(*) Red asterisk indicates a required field.
Record Demographics
Objective: Record demographics
preferred language
gender
race
ethnicity
date of birth
Measure: More than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have demographics recorded as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who have all the elements of demographics (or a specific exclusion if the patient declined to provide one or more elements or if recording an element is contrary to state law) recorded as structured data.
Denominator Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

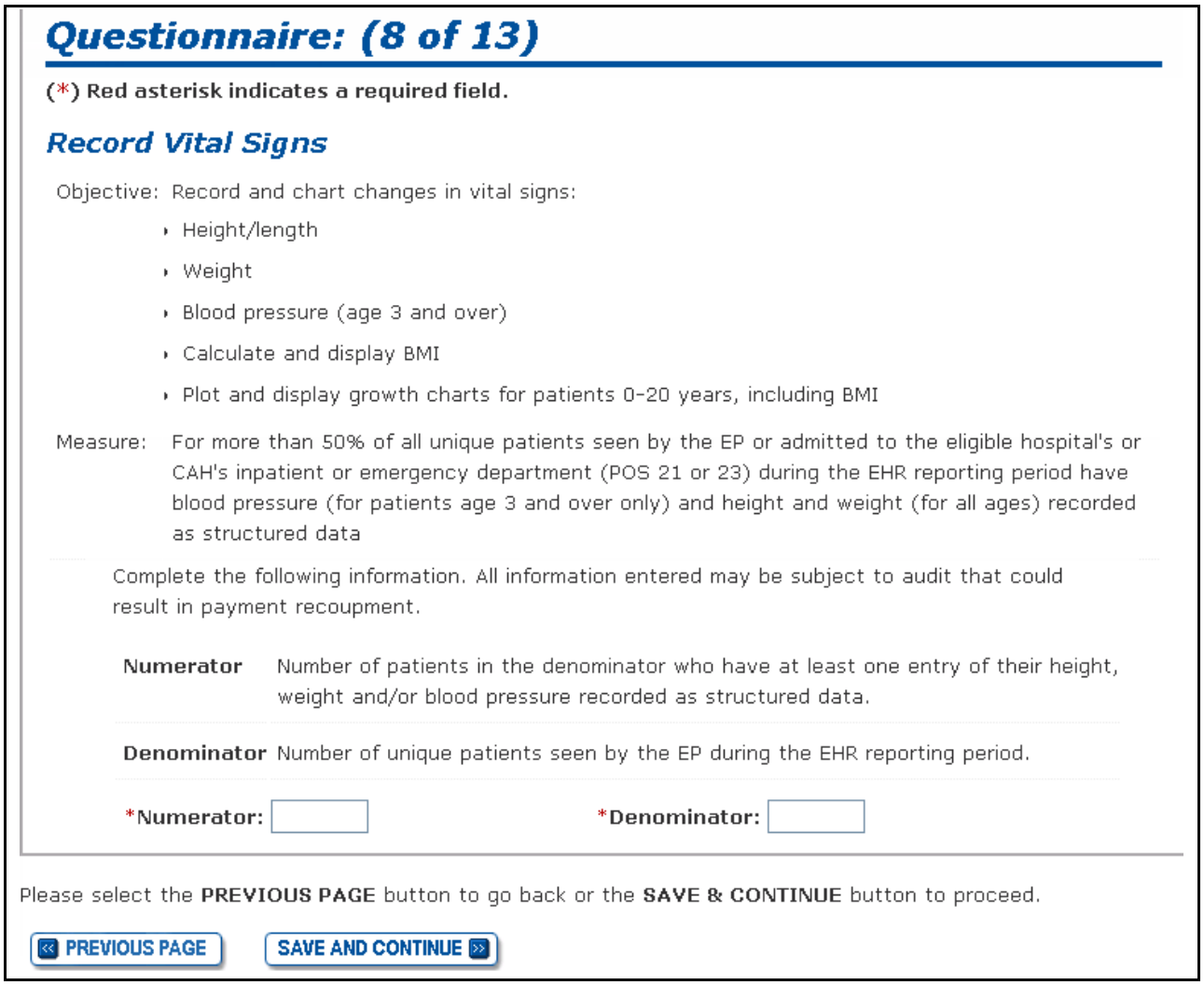
Meaningful Use Core Question 7 – Record Demographics


Questionnaire: (8 of 13)
(*) Red asterisk indicates a required field.
Record Vital Signs
Objective: Record and chart changes in vital signs:
Height/length
Weight
Blood pressure (age 3 and over)
Calculate and display BMI
Plot and display growth charts for patients 0-20 years, including BMI
Measure: For more than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
EXCLUSION - Based on ALL patient records: Any EP who sees no patients 3 years or older is excluded from recording blood pressure. Any EP who believes that all 3 vital signs of height/length, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them. Any EP who believes that height/length and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure. Any EP who believes that blood pressure is relevant to their scope of practice, but height/length and weight are not, is excluded from recording height/length and weight.
*Please select the exclusion option that applies to you.
1
Any EP who sees no patients 3 years or older is excluded from recording blood pressure.
2
Any EP who believes that all three vital signs of height, weight, and blood pressure have no relevance to their scope of practice is excluded from recording them.
3
Any EP who believes that height and weight are relevant to their scope of practice, but blood pressure is not, is excluded from recording blood pressure.
4
Any EP who believes that blood pressure is relevant to their scope of practice, but height and weight are not, is excluded from recording height and weight.
5
None of the above exclusions apply to me.
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

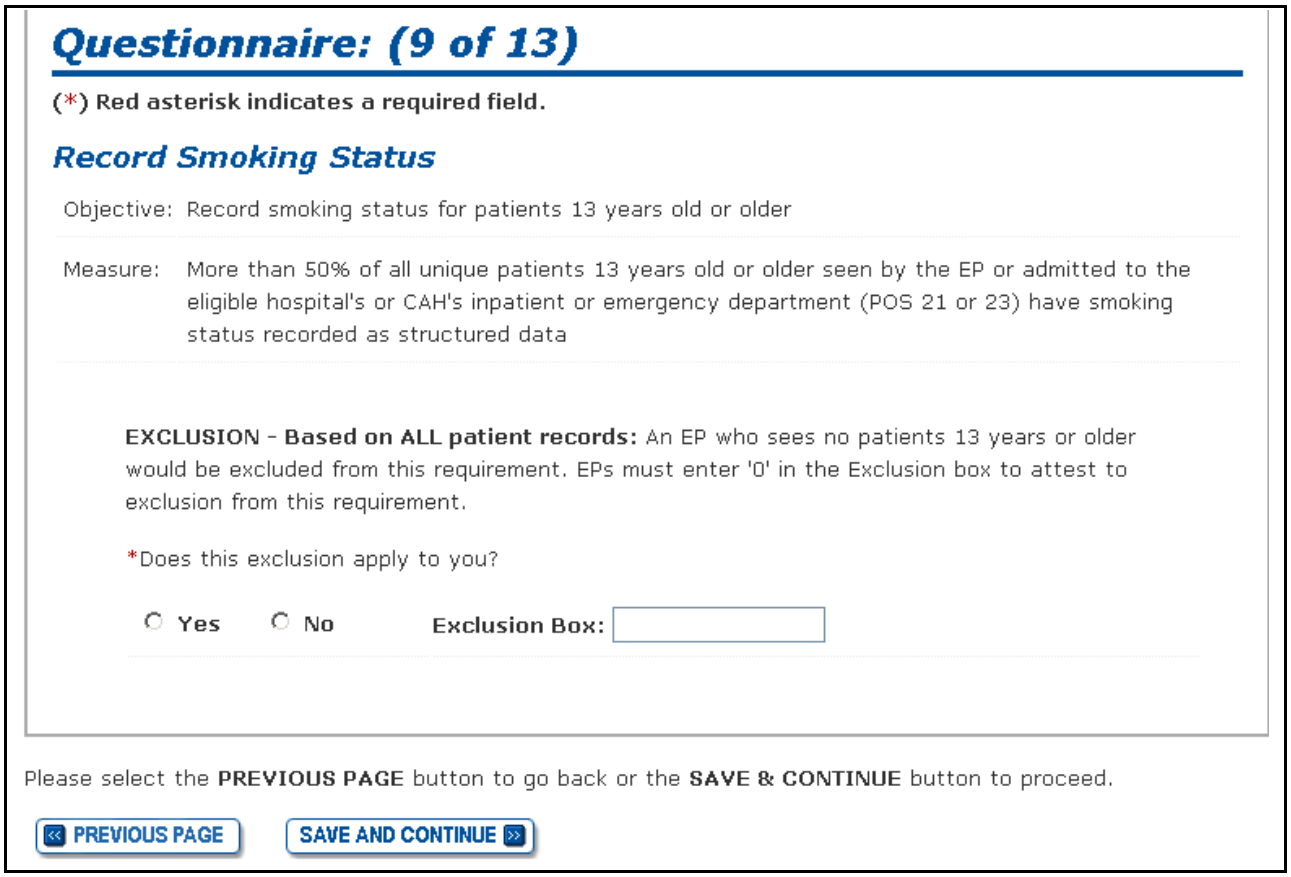
Meaningful Use Core Question 8 - Record vitals

If provider selects exclusions 2 illustrated in the screenshot, then the next question displays. This means that the exclusion is claimed and the provider will not enter a numerator and denominator.

If the provider selects exclusions 1, 3, 4 or 5 illustrated in the screenshot, then the provider will enter in the numerator and denominator for this MU question using the existing numerator and denominator entry screen shown below.


Questionnaire: (8 of 13)
(*) Red asterisk indicates a required field.
Record Vital Signs
Objective: Record and chart changes in vital signs:
Height/length
Weight
Blood pressure (age 3 and over)
Calculate and display BMI
Plot and display growth charts for patients 0-20 years, including BMI
Measure: For more than 50% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have blood pressure (for patients age 3 and over only) and height and weight (for all ages) recorded as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who have at least one entry of their height, weight and/or blood pressure recorded as structured data.
Denominator Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Meaningful Use Core – Record Vitals exclusion



Questionnaire: (9 of 13)

(*) Red asterisk indicates a required field.

Record Smoking Status

Objective: Record smoking status for patients 13 years old or older

Measure: More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data

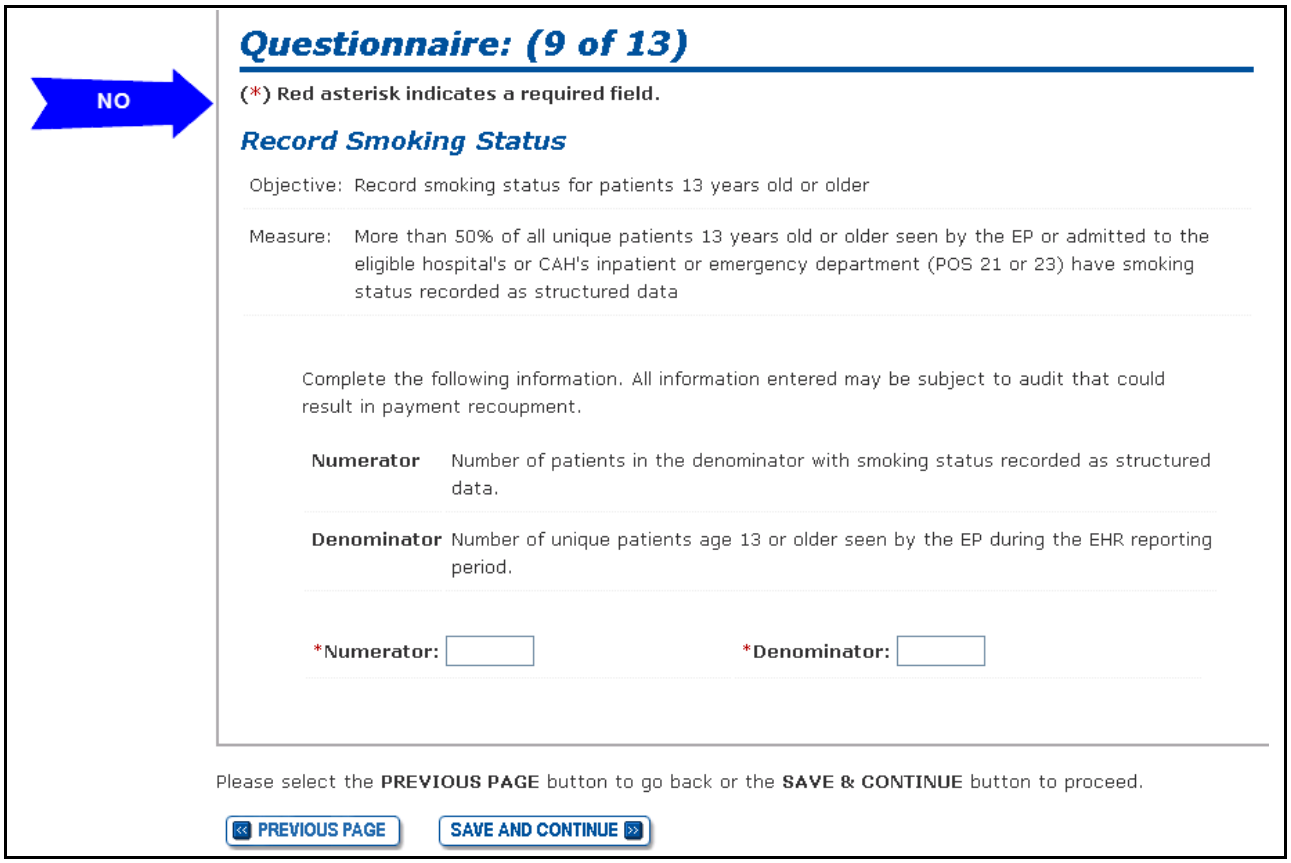
EXCLUSION - Based on ALL patient records: An EP who sees no patients 13 years or older would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

*Does this exclusion apply to you?

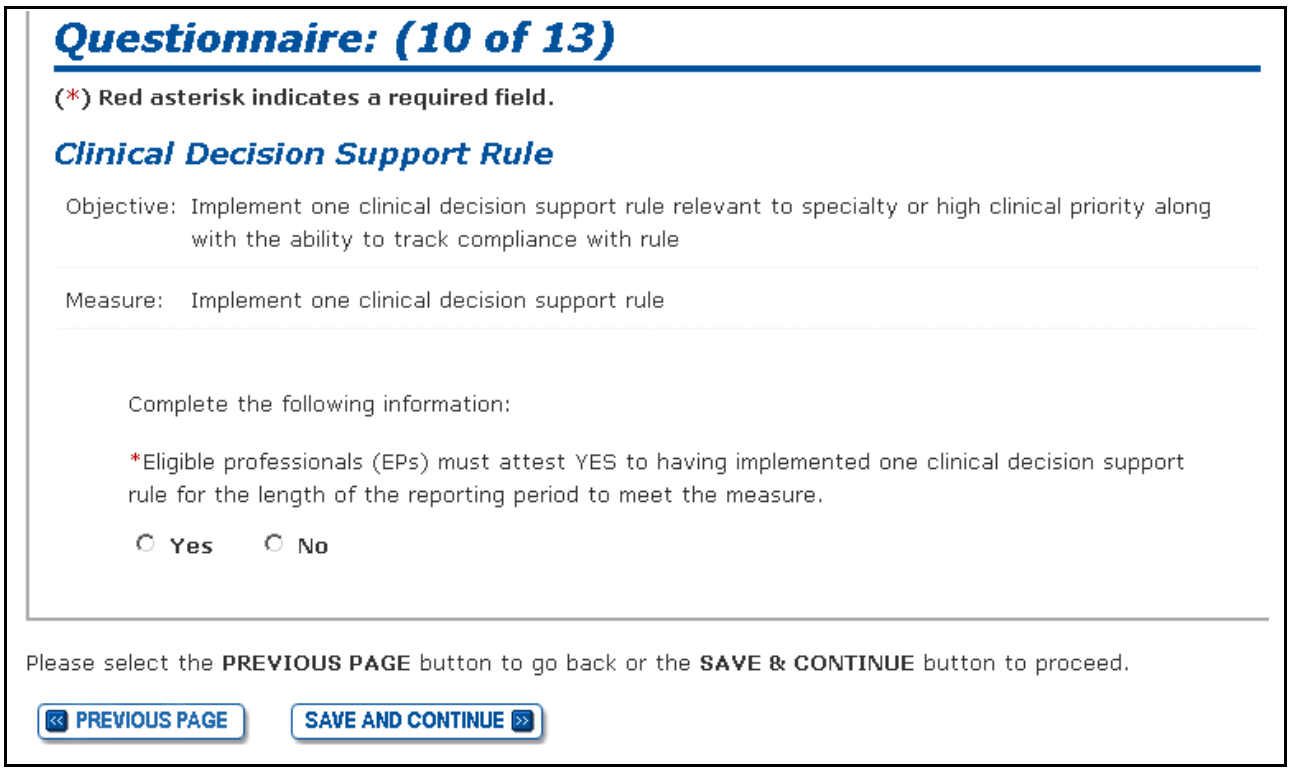
Yes No **Exclusion Box:**

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

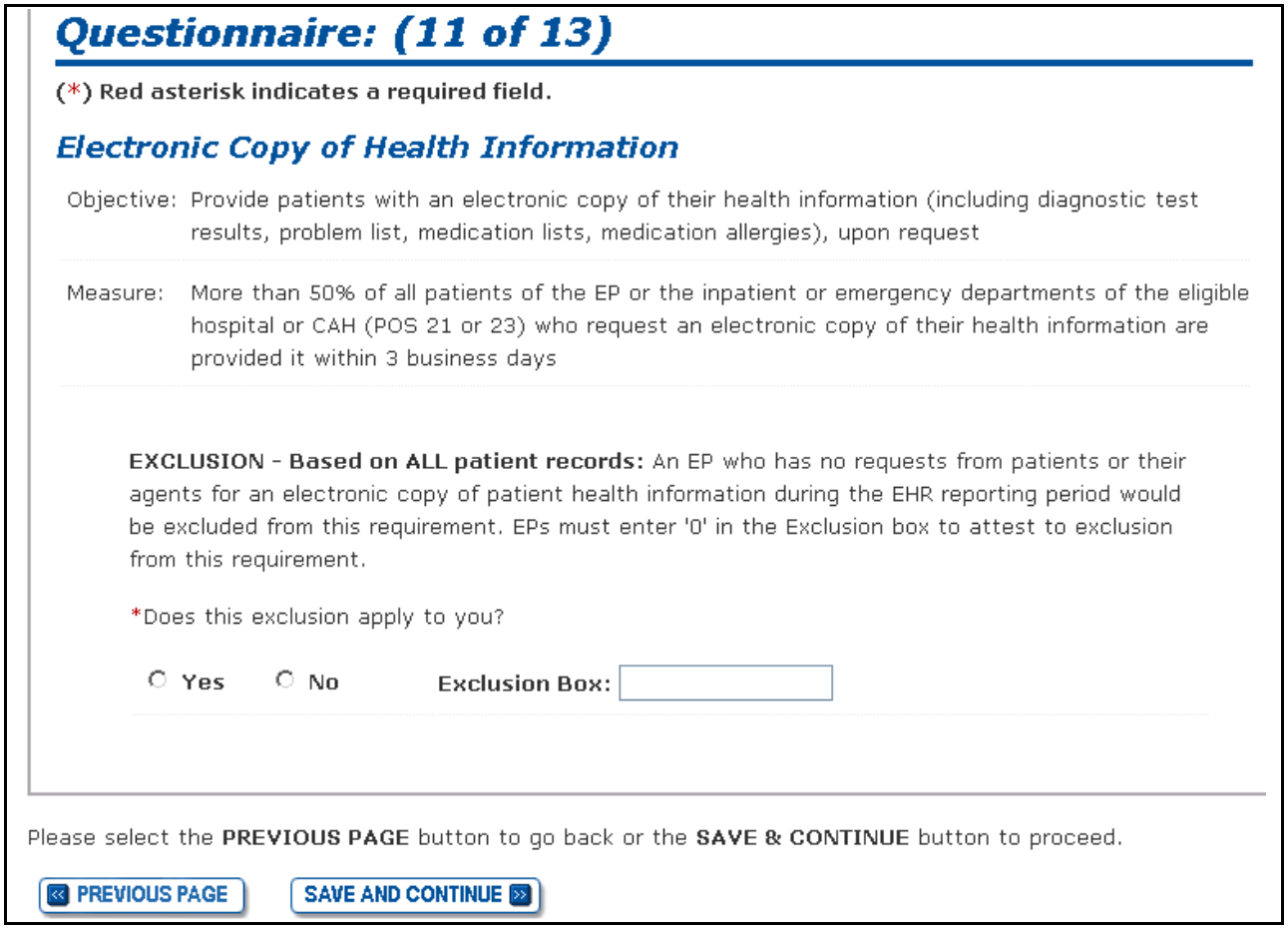
PREVIOUS PAGE SAVE AND CONTINUE


NO
Questionnaire: (9 of 13)
(*) Red asterisk indicates a required field.
Record Smoking Status
Objective: Record smoking status for patients 13 years old or older
Measure: More than 50% of all unique patients 13 years old or older seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) have smoking status recorded as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator with smoking status recorded as structured data.
Denominator Number of unique patients age 13 or older seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Meaningful Use Core Question 9 – Record Smoking Status and answer No to exclusion


Questionnaire: (10 of 13)
(*) Red asterisk indicates a required field.
Clinical Decision Support Rule
Objective: Implement one clinical decision support rule relevant to specialty or high clinical priority along with the ability to track compliance with rule
Measure: Implement one clinical decision support rule
Complete the following information:
*Eligible professionals (EPs) must attest YES to having implemented one clinical decision support rule for the length of the reporting period to meet the measure.
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Meaningful Use Core Question 10 – Clinical Decision Support Rule



Questionnaire: (11 of 13)

(*) Red asterisk indicates a required field.

Electronic Copy of Health Information

Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request

Measure: More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days

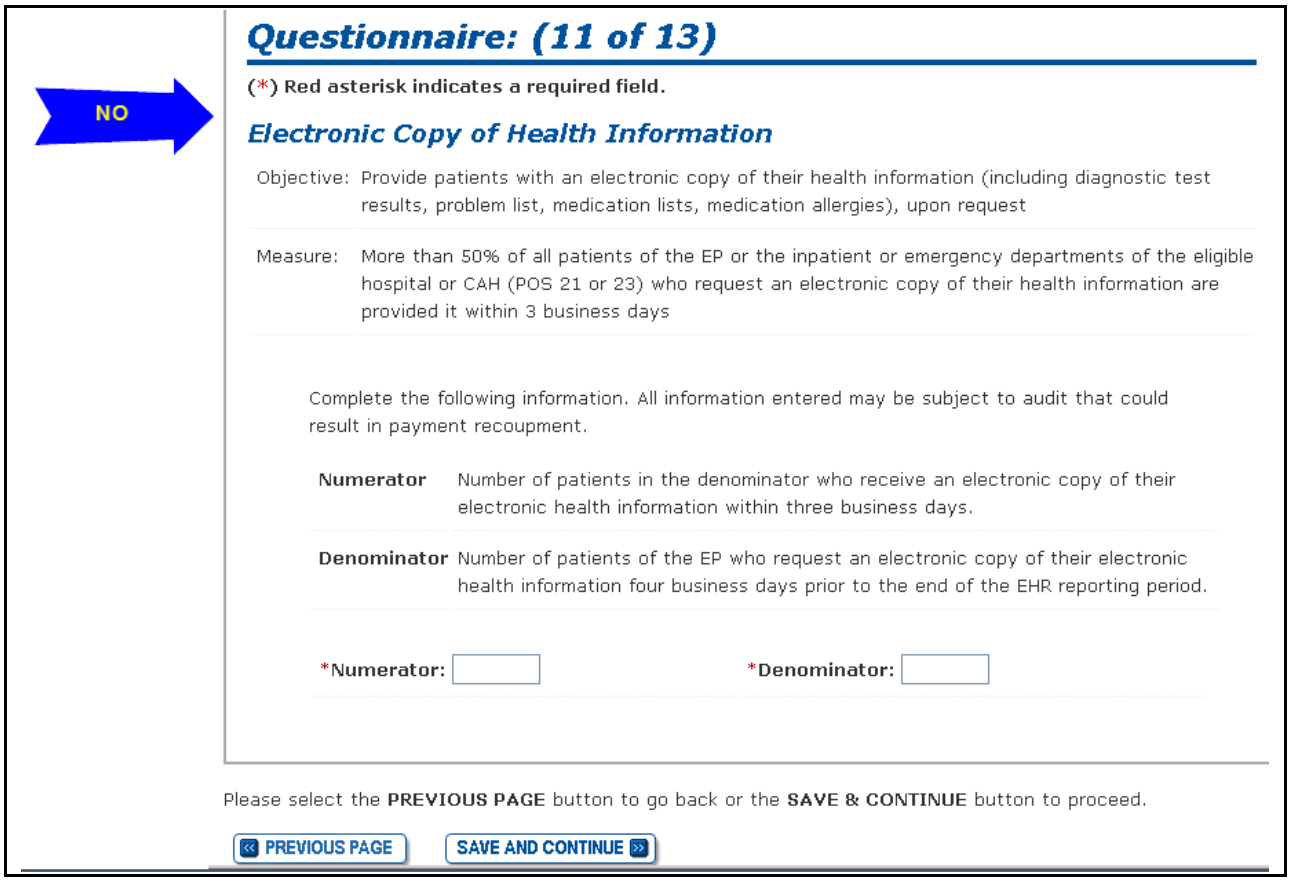
EXCLUSION - Based on ALL patient records: An EP who has no requests from patients or their agents for an electronic copy of patient health information during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

*Does this exclusion apply to you?

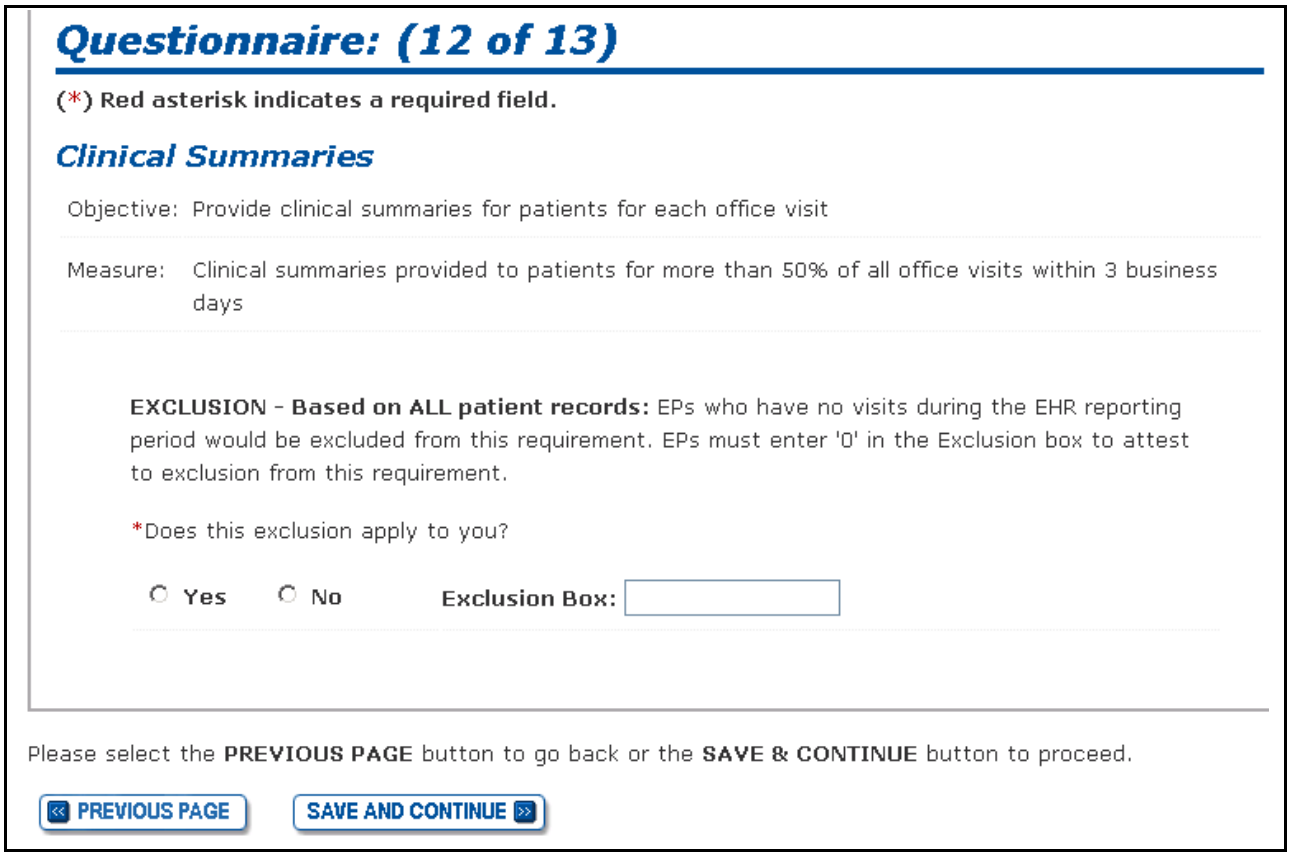
○ Yes ○ No **Exclusion Box:**

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE


NO
Questionnaire: (11 of 13)
(*) Red asterisk indicates a required field.
Electronic Copy of Health Information
Objective: Provide patients with an electronic copy of their health information (including diagnostic test results, problem list, medication lists, medication allergies), upon request
Measure: More than 50% of all patients of the EP or the inpatient or emergency departments of the eligible hospital or CAH (POS 21 or 23) who request an electronic copy of their health information are provided it within 3 business days
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who receive an electronic copy of their electronic health information within three business days.
Denominator Number of patients of the EP who request an electronic copy of their electronic health information four business days prior to the end of the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Meaningful Use Core Question 11 – Electronic Copy of Health Information and answer No to exclusion



Questionnaire: (12 of 13)

(*) Red asterisk indicates a required field.

Clinical Summaries

Objective: Provide clinical summaries for patients for each office visit

Measure: Clinical summaries provided to patients for more than 50% of all office visits within 3 business days

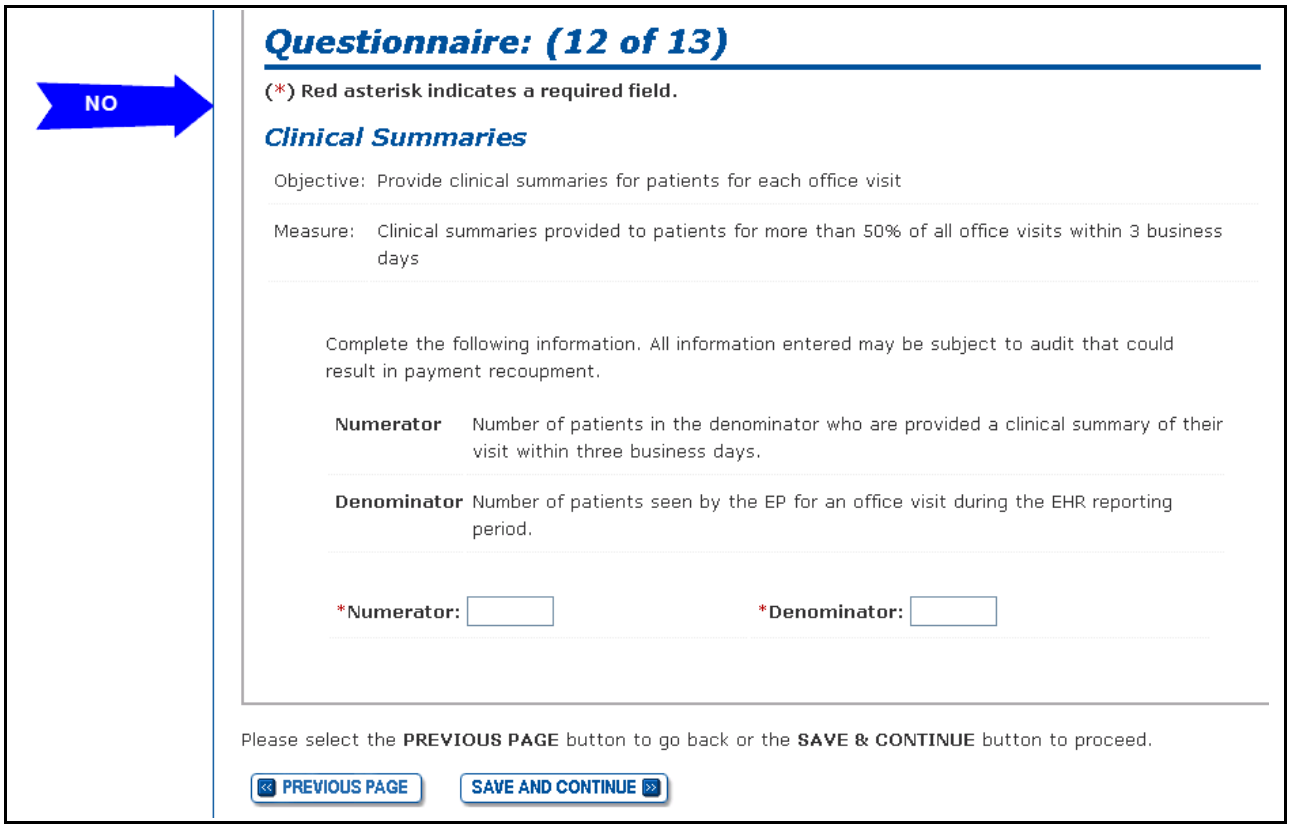
EXCLUSION - Based on ALL patient records: EPs who have no visits during the EHR reporting period would be excluded from this requirement. EPs must enter '0' in the Exclusion box to attest to exclusion from this requirement.

*Does this exclusion apply to you?

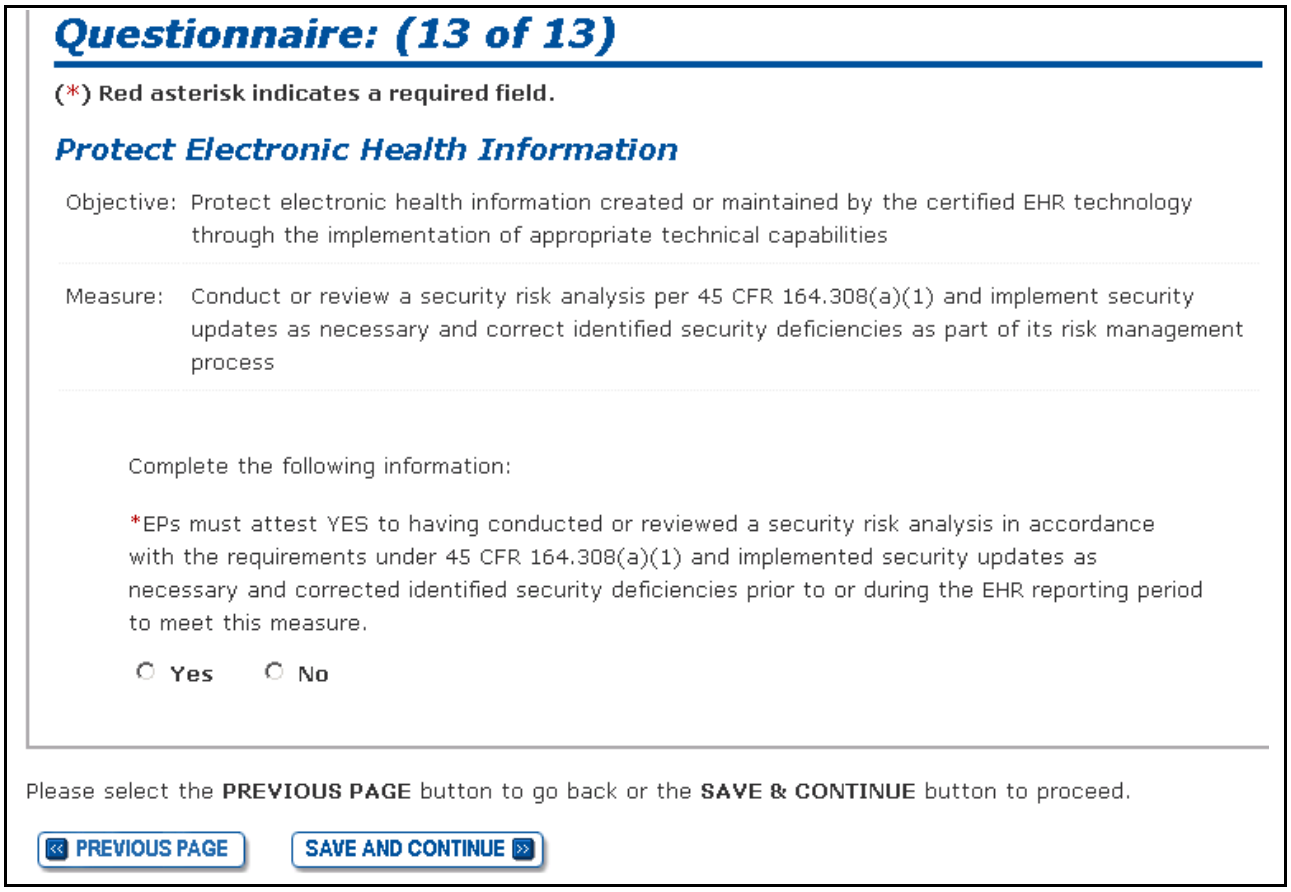
Yes No **Exclusion Box:**

Please select the **PREVIOUS PAGE** button to go back or the **SAVE & CONTINUE** button to proceed.

PREVIOUS PAGE SAVE AND CONTINUE


NO
Questionnaire: (12 of 13)
(*) Red asterisk indicates a required field.
Clinical Summaries
Objective: Provide clinical summaries for patients for each office visit
Measure: Clinical summaries provided to patients for more than 50% of all office visits within 3 business days
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who are provided a clinical summary of their visit within three business days.
Denominator Number of patients seen by the EP for an office visit during the EHR reporting period.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

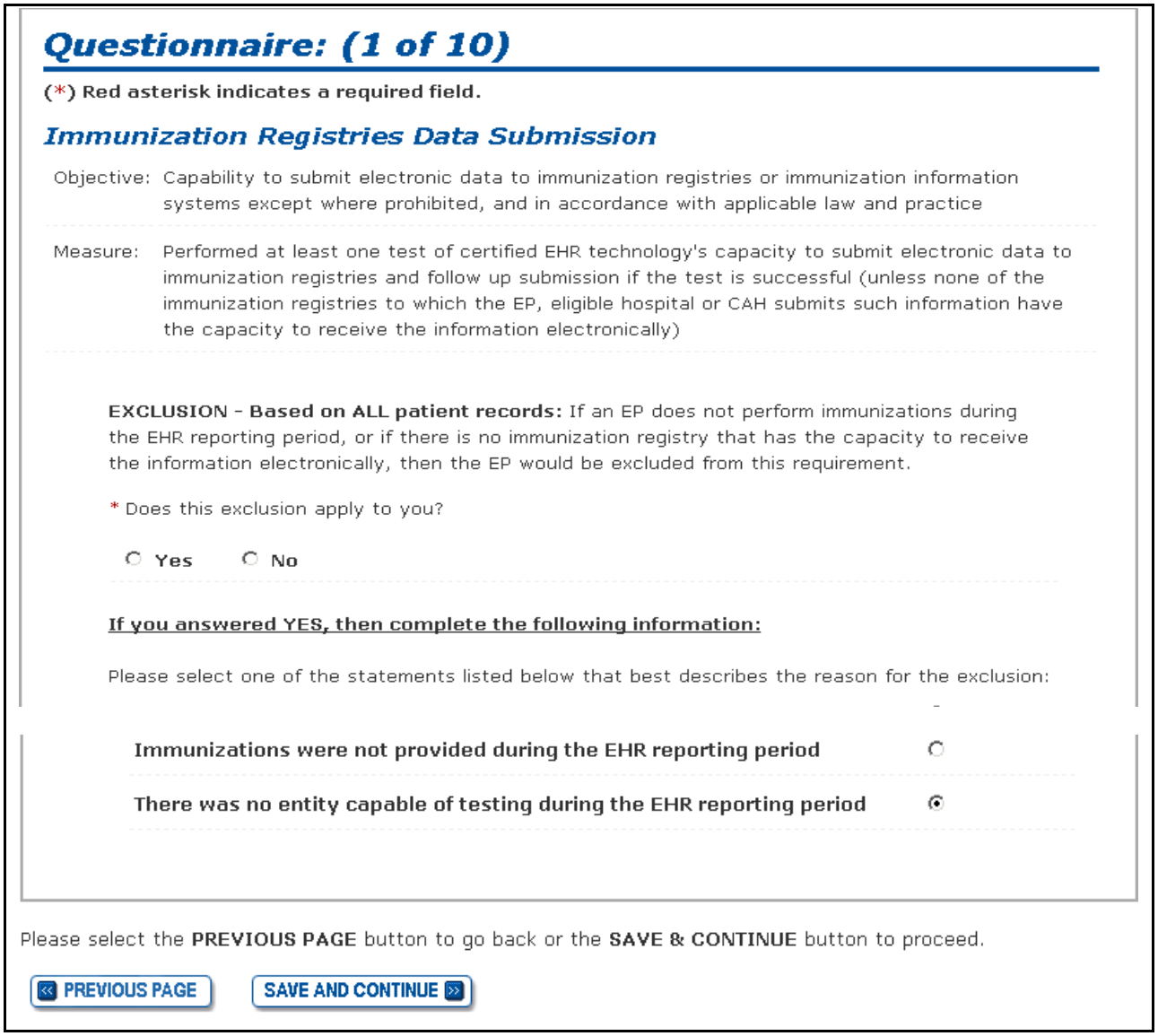
Meaningful Use Core Question 12 – Clinical Summaries and answer No to exclusion


Questionnaire: (13 of 13)
(*) Red asterisk indicates a required field.
Protect Electronic Health Information
Objective: Protect electronic health information created or maintained by the certified EHR technology through the implementation of appropriate technical capabilities
Measure: Conduct or review a security risk analysis per 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process
Complete the following information:
*EPs must attest YES to having conducted or reviewed a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implemented security updates as necessary and corrected identified security deficiencies prior to or during the EHR reporting period to meet this measure.
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

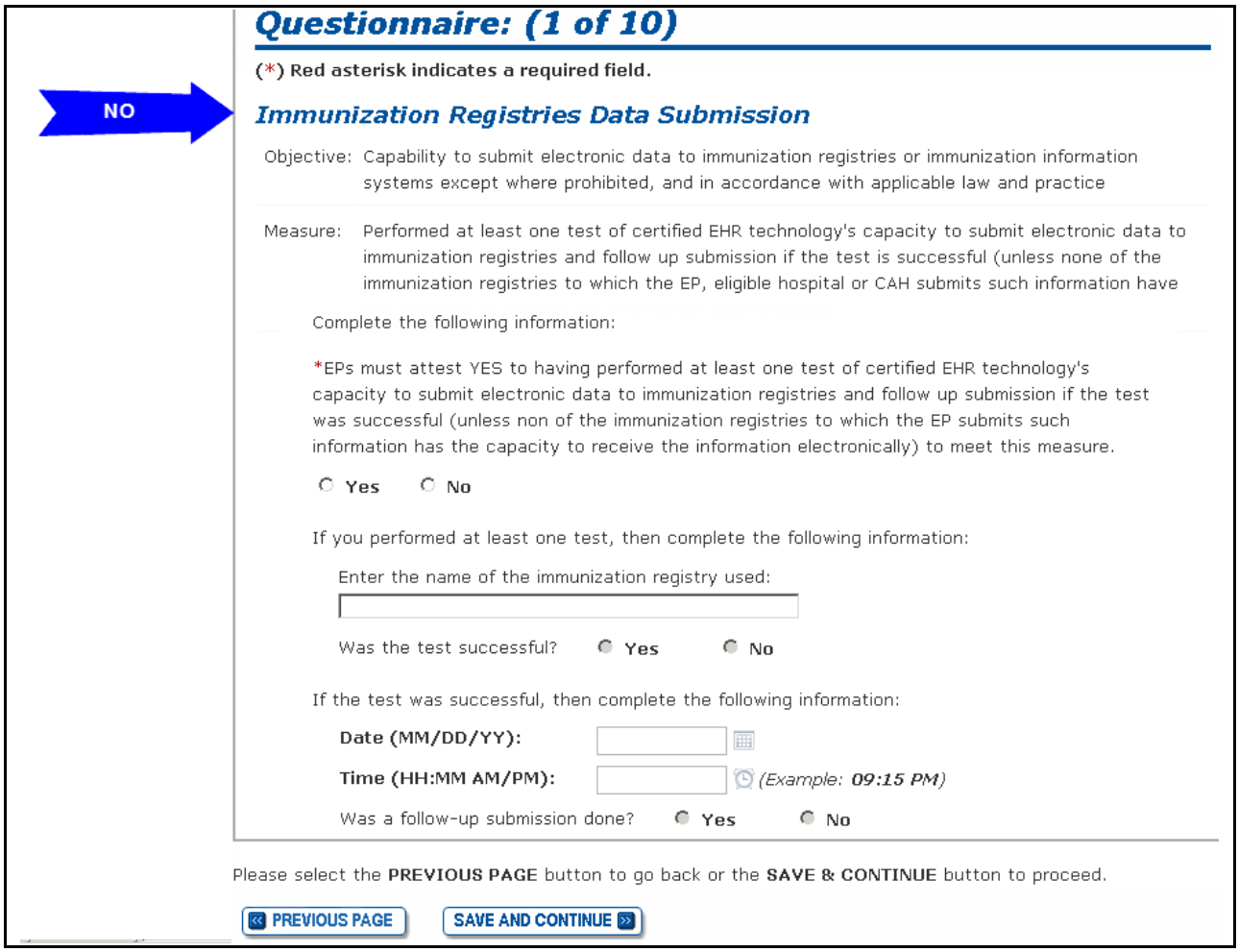
Meaningful Use Core Question 13 – Protect Electronic Health Information

29. Meaningful Use Menu Measures Screen Shots

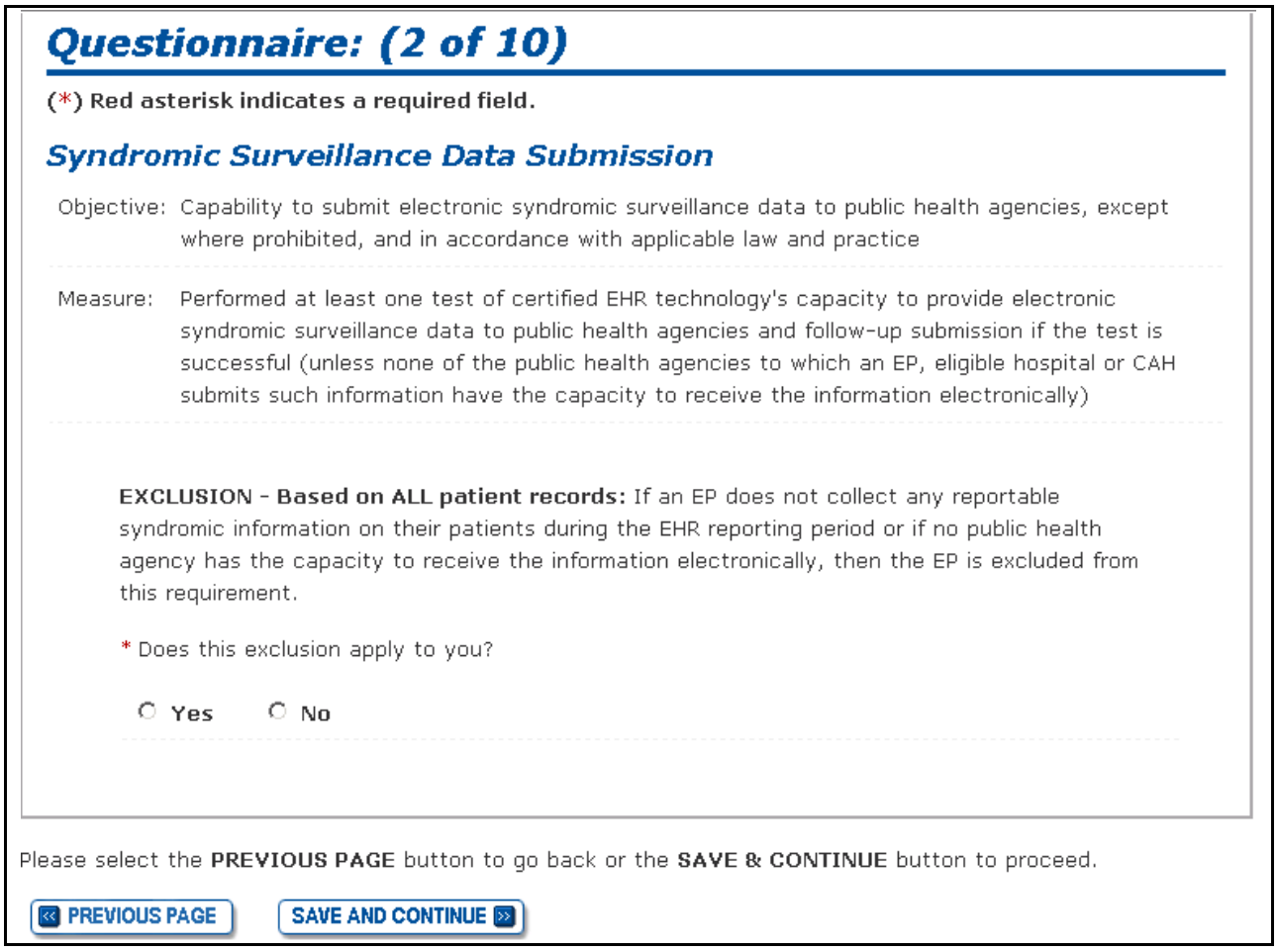
CMS requires that minimum of five questions are selected. All ten question screen shots are displayed. The application will display the questions that are selected by the user.


Questionnaire: (1 of 10)
(*) Red asterisk indicates a required field.
Immunization Registries Data Submission
Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice
Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)
EXCLUSION - Based on ALL patient records: If an EP does not perform immunizations during the EHR reporting period, or if there is no immunization registry that has the capacity to receive the information electronically, then the EP would be excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
If you answered YES, then complete the following information:
Please select one of the statements listed below that best describes the reason for the exclusion:
Immunizations were not provided during the EHR reporting period
There was no entity capable of testing during the EHR reporting period
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

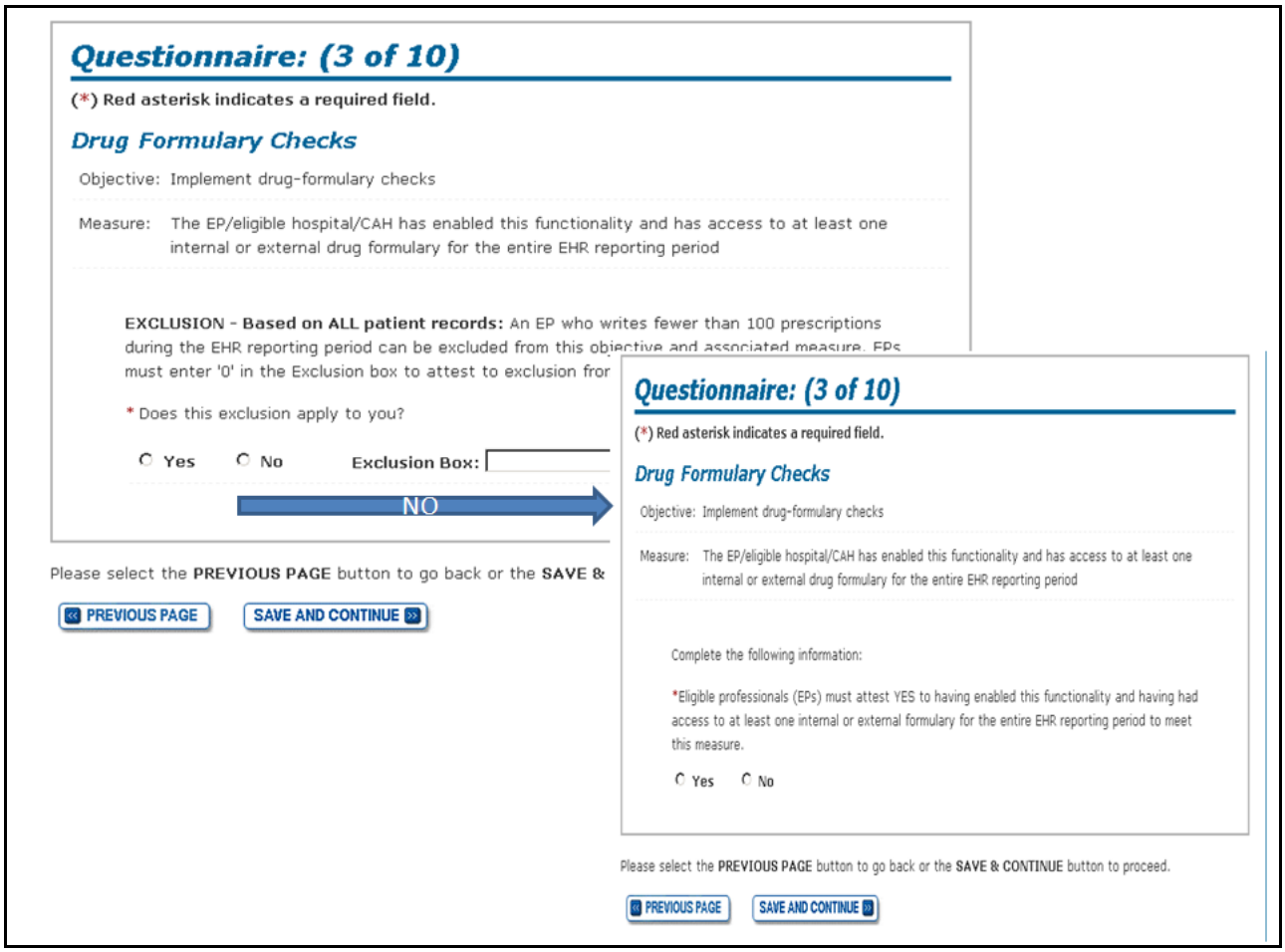
Meaningful Use Menu Measures Question 1 – Immunization Registries Data Submission


NO
Questionnaire: (1 of 10)
(*) Red asterisk indicates a required field.
Immunization Registries Data Submission
Objective: Capability to submit electronic data to immunization registries or immunization information systems except where prohibited, and in accordance with applicable law and practice
Measure: Performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test is successful (unless none of the immunization registries to which the EP, eligible hospital or CAH submits such information have
Complete the following information:
*EPs must attest YES to having performed at least one test of certified EHR technology's capacity to submit electronic data to immunization registries and follow up submission if the test was successful (unless non of the immunization registries to which the EP submits such information has the capacity to receive the information electronically) to meet this measure.
Yes
No
If you performed at least one test, then complete the following information:
Enter the name of the immunization registry used:
Was the test successful?
Yes
No
If the test was successful, then complete the following information:
Date (MM/DD/YY):
Time (HH:MM AM/PM):
(Example: 09:15 PM)
Was a follow-up submission done?
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

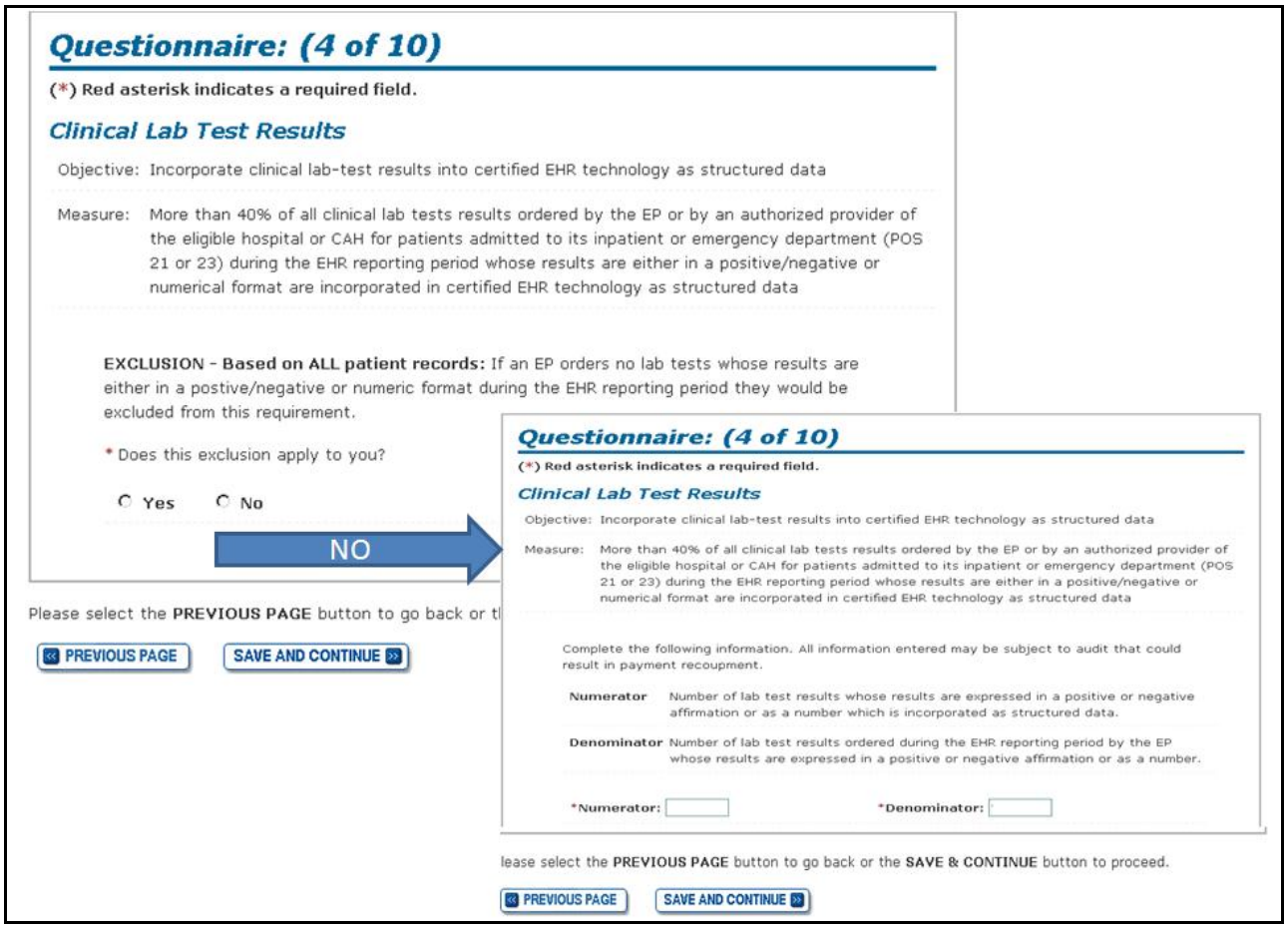
Meaningful Use Menu Measures Question 1 – Immunization Registries answered No to exclusion


Questionnaire: (2 of 10)
(*) Red asterisk indicates a required field.
Syndromic Surveillance Data Submission
Objective: Capability to submit electronic syndromic surveillance data to public health agencies, except where prohibited, and in accordance with applicable law and practice
Measure: Performed at least one test of certified EHR technology's capacity to provide electronic syndromic surveillance data to public health agencies and follow-up submission if the test is successful (unless none of the public health agencies to which an EP, eligible hospital or CAH submits such information have the capacity to receive the information electronically)
EXCLUSION - Based on ALL patient records: If an EP does not collect any reportable syndromic information on their patients during the EHR reporting period or if no public health agency has the capacity to receive the information electronically, then the EP is excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

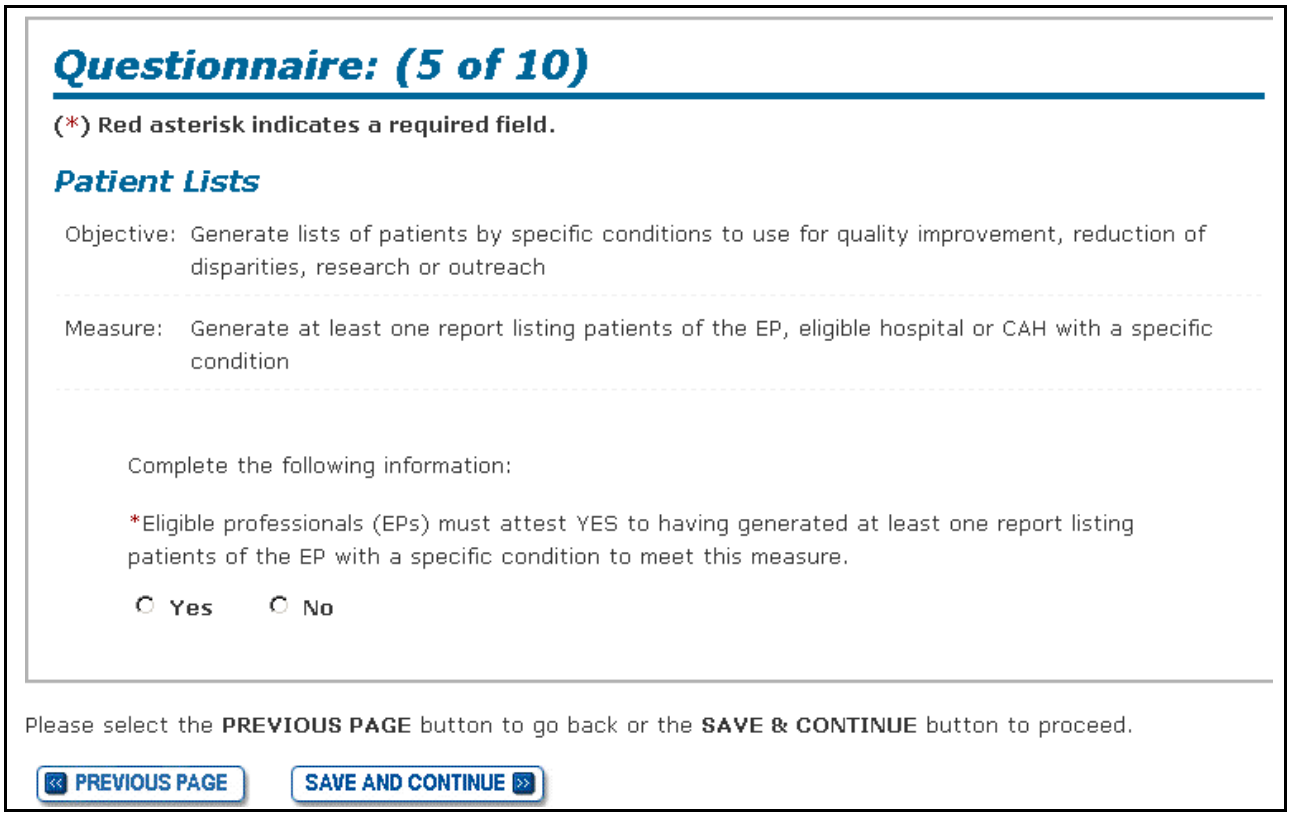
Meaningful Use Menu Measures Question 2 – Syndromic Surveillance Data Submission


Questionnaire: (3 of 10)
(*) Red asterisk indicates a required field.
Drug Formulary Checks
Objective: Implement drug-formulary checks
Measure: The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
EXCLUSION - Based on ALL patient records: An EP who writes fewer than 100 prescriptions during the EHR reporting period can be excluded from this objective and associated measure. EPs must enter '0' in the Exclusion box to attest to exclusion fror
* Does this exclusion apply to you?
Yes
No
Exclusion Box:
NO
Please select the PREVIOUS PAGE button to go back or the SAVE &
PREVIOUS PAGE
SAVE AND CONTINUE
Questionnaire: (3 of 10)
(*) Red asterisk indicates a required field.
Drug Formulary Checks
Objective: Implement drug-formulary checks
Measure: The EP/eligible hospital/CAH has enabled this functionality and has access to at least one internal or external drug formulary for the entire EHR reporting period
Complete the following information:
*Eligible professionals (EPs) must attest YES to having enabled this functionality and having had access to at least one internal or external formulary for the entire EHR reporting period to meet this measure.
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

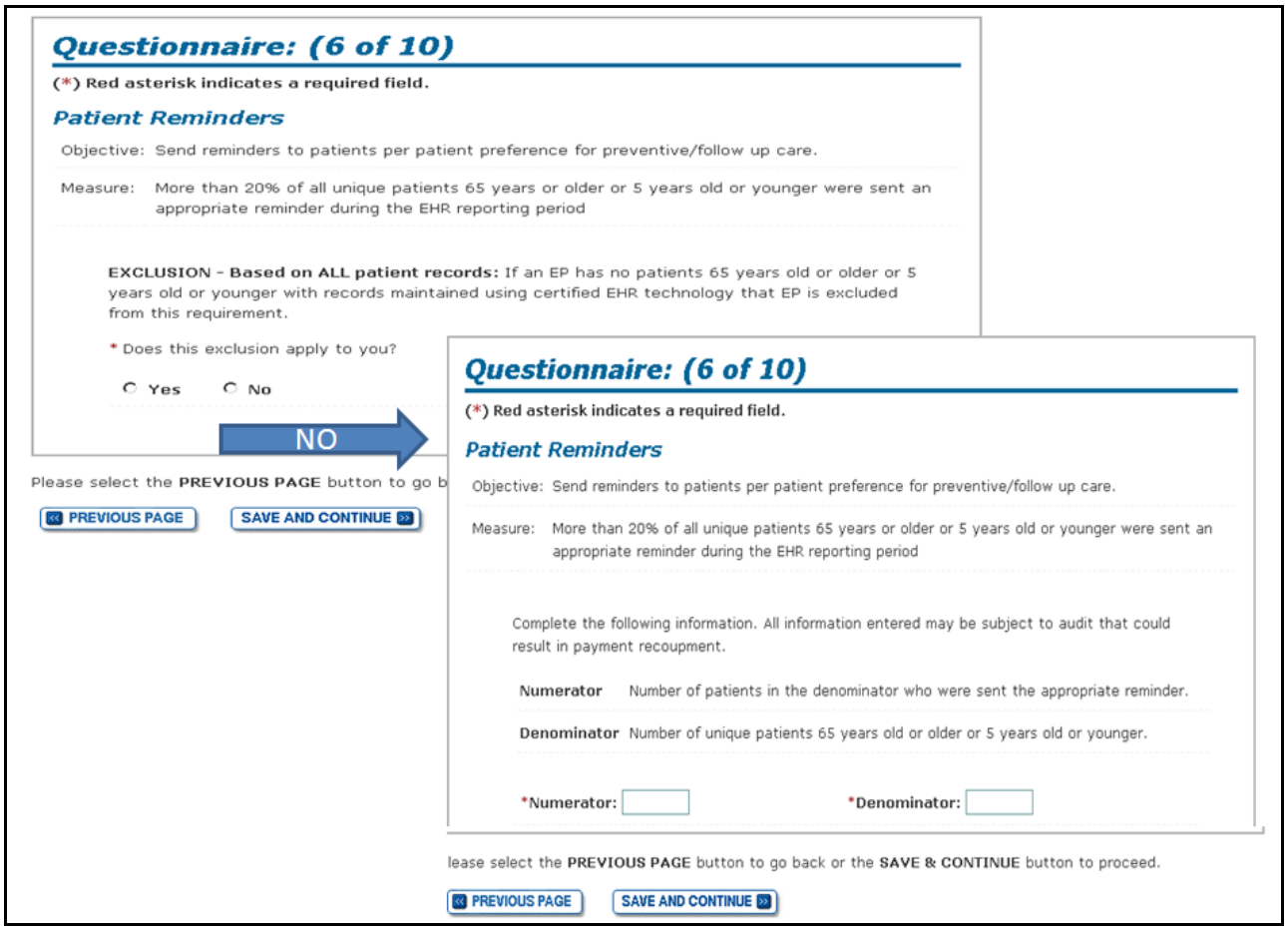
Meaningful Use Menu Measure Question 3 – Drug Formulary Checks and answer No to exclusion


Questionnaire: (4 of 10)
(*) Red asterisk indicates a required field.
Clinical Lab Test Results
Objective: Incorporate clinical lab-test results into certified EHR technology as structured data
Measure: More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
EXCLUSION - Based on ALL patient records: If an EP orders no lab tests whose results are either in a postive/negative or numeric format during the EHR reporting period they would be excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
NO
Please select the PREVIOUS PAGE button to go back or t
PREVIOUS PAGE
SAVE AND CONTINUE
Questionnaire: (4 of 10)
(*) Red asterisk indicates a required field.
Clinical Lab Test Results
Objective: Incorporate clinical lab-test results into certified EHR technology as structured data
Measure: More than 40% of all clinical lab tests results ordered by the EP or by an authorized provider of the eligible hospital or CAH for patients admitted to its inpatient or emergency department (POS 21 or 23) during the EHR reporting period whose results are either in a positive/negative or numerical format are incorporated in certified EHR technology as structured data
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of lab test results whose results are expressed in a positive or negative affirmation or as a number which is incorporated as structured data.
Denominator Number of lab test results ordered during the EHR reporting period by the EP whose results are expressed in a positive or negative affirmation or as a number.
*Numerator:
*Denominator:
lease select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

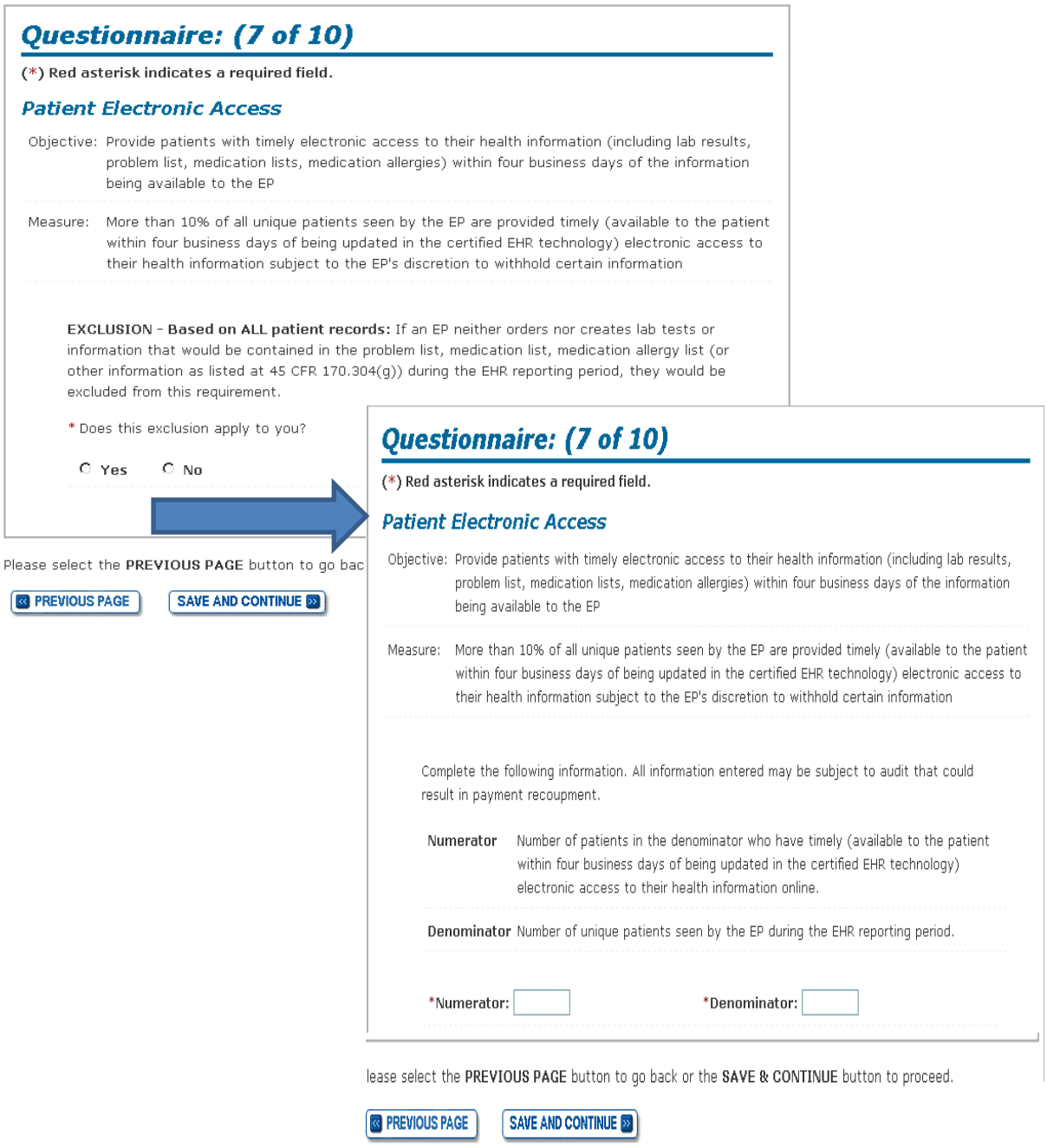
Meaningful Use Menu Measure Question 4 – Clinical Lab Test Results and answer No to exclusion


Questionnaire: (5 of 10)
(*) Red asterisk indicates a required field.
Patient Lists
Objective: Generate lists of patients by specific conditions to use for quality improvement, reduction of disparities, research or outreach
Measure: Generate at least one report listing patients of the EP, eligible hospital or CAH with a specific condition
Complete the following information:
*Eligible professionals (EPs) must attest YES to having generated at least one report listing patients of the EP with a specific condition to meet this measure.
Yes
No
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

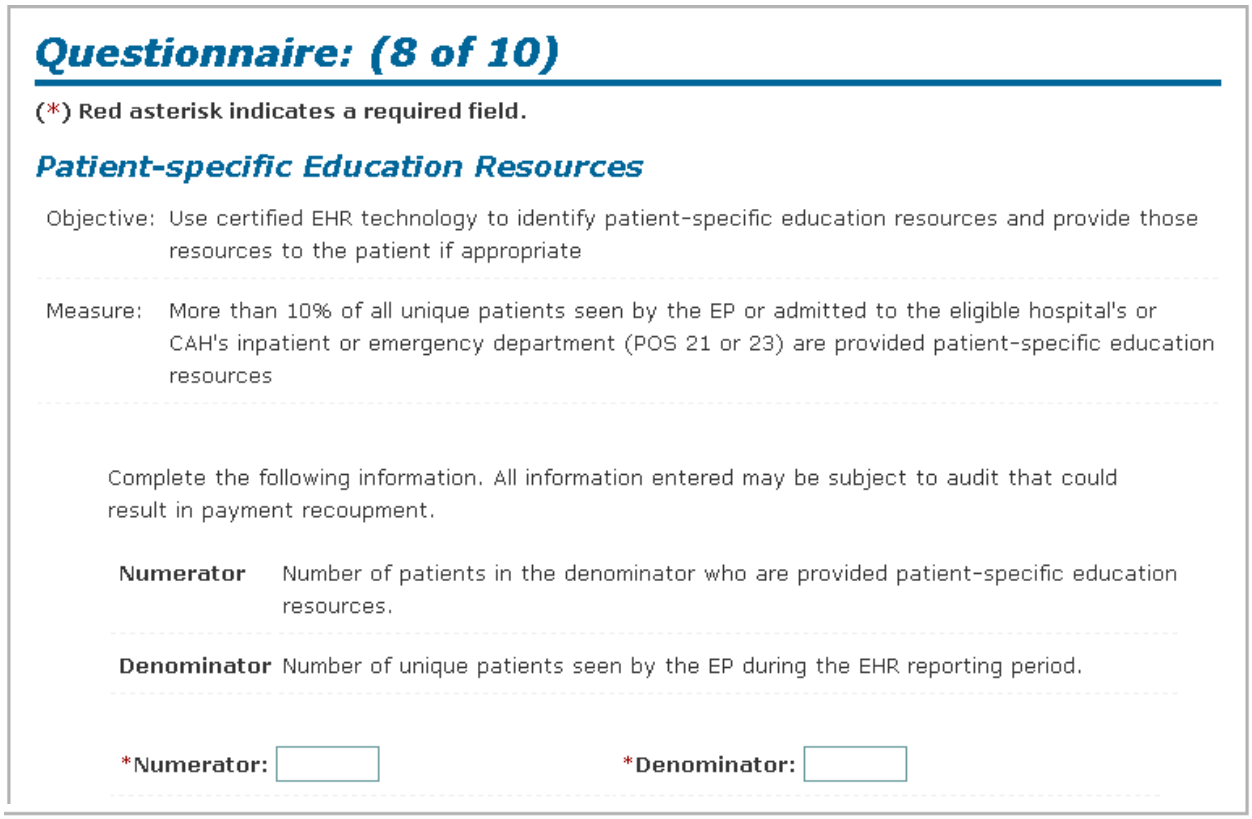
Meaningful Use Menu Measures Question 5 – Patient Lists


Questionnaire: (6 of 10)
(*) Red asterisk indicates a required field.
Patient Reminders
Objective: Send reminders to patients per patient preference for preventive/follow up care.
Measure: More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period
EXCLUSION - Based on ALL patient records: If an EP has no patients 65 years old or older or 5 years old or younger with records maintained using certified EHR technology that EP is excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
NO
Please select the PREVIOUS PAGE button to go b
PREVIOUS PAGE
SAVE AND CONTINUE
Questionnaire: (6 of 10)
(*) Red asterisk indicates a required field.
Patient Reminders
Objective: Send reminders to patients per patient preference for preventive/follow up care.
Measure: More than 20% of all unique patients 65 years or older or 5 years old or younger were sent an appropriate reminder during the EHR reporting period
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who were sent the appropriate reminder.
Denominator Number of unique patients 65 years old or older or 5 years old or younger.
*Numerator:
*Denominator:
lease select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

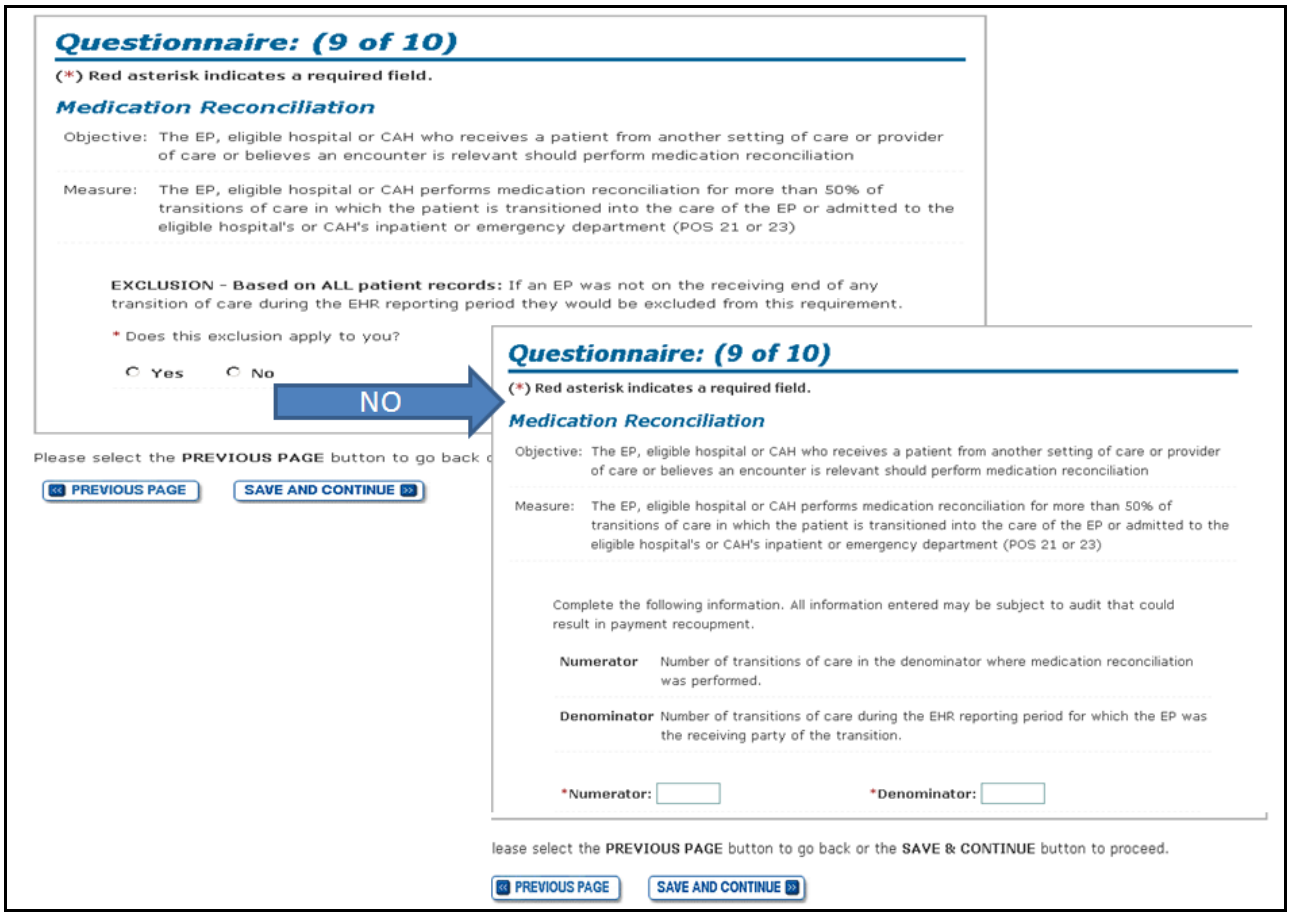
Meaningful Use Menu Measures Question 6 – Patient Reminders and answer No to exclusion


Questionnaire: (7 of 10)
(*) Red asterisk indicates a required field.
Patient Electronic Access
Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP
Measure: More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
EXCLUSION - Based on ALL patient records: If an EP neither orders nor creates lab tests or information that would be contained in the problem list, medication list, medication allergy list (or other information as listed at 45 CFR 170.304(g)) during the EHR reporting period, they would be excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
Please select the PREVIOUS PAGE button to go bac
PREVIOUS PAGE
SAVE AND CONTINUE
Questionnaire: (7 of 10)
(*) Red asterisk indicates a required field.
Patient Electronic Access
Objective: Provide patients with timely electronic access to their health information (including lab results, problem list, medication lists, medication allergies) within four business days of the information being available to the EP
Measure: More than 10% of all unique patients seen by the EP are provided timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information subject to the EP's discretion to withhold certain information
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who have timely (available to the patient within four business days of being updated in the certified EHR technology) electronic access to their health information online.
Denominator Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
lease select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

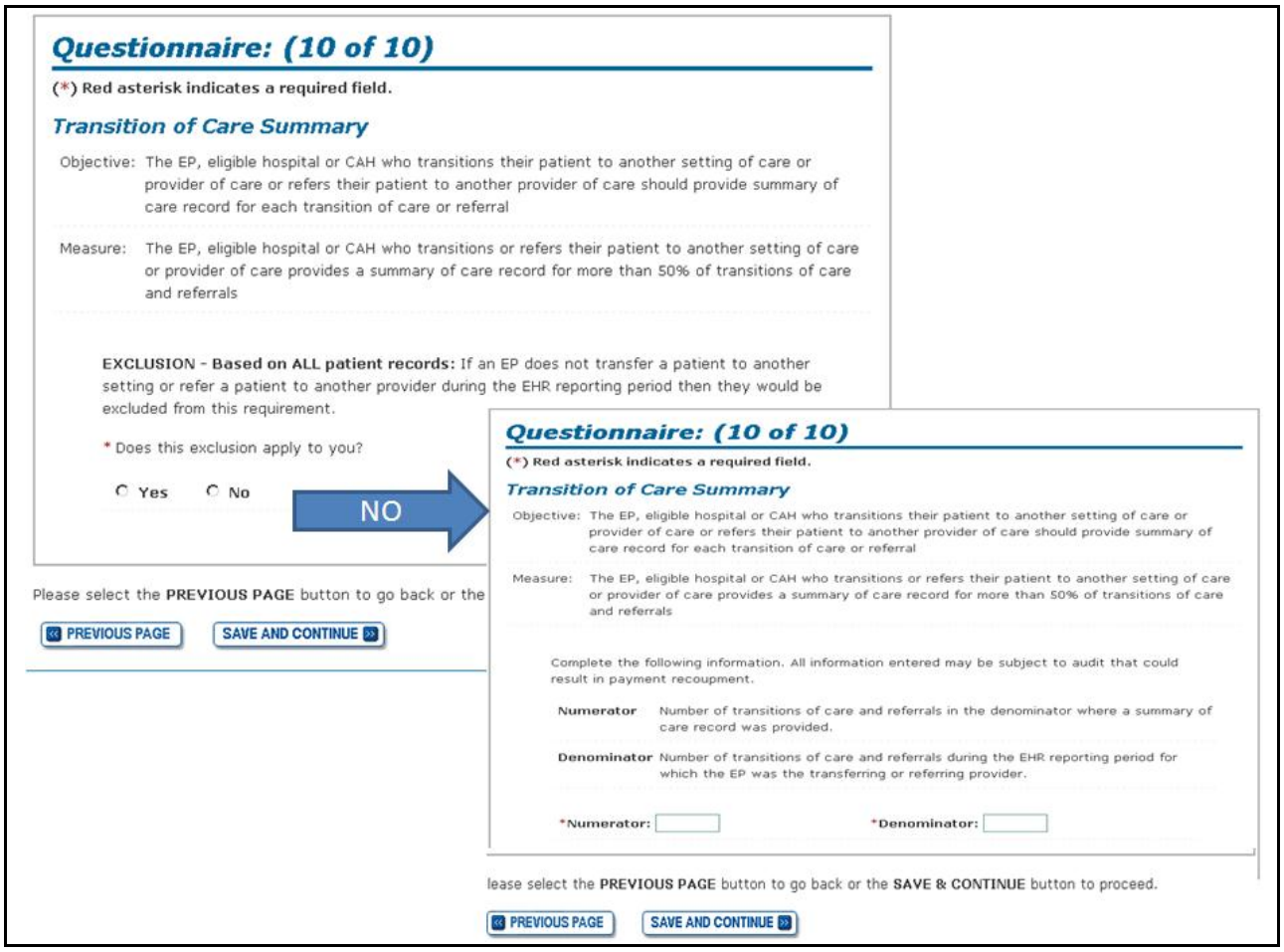
Meaningful Use Menu Measures Question 7 – Patient Electronic Access and answer No to exclusion


Questionnaire: (8 of 10)
(*) Red asterisk indicates a required field.
Patient-specific Education Resources
Objective: Use certified EHR technology to identify patient-specific education resources and provide those resources to the patient if appropriate
Measure: More than 10% of all unique patients seen by the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient-specific education resources
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of patients in the denominator who are provided patient-specific education resources.
Denominator Number of unique patients seen by the EP during the EHR reporting period.
*Numerator:
*Denominator:
lease select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Meaningful Use Menu Measure Question 8 – Patient-specific Education Resources


Questionnaire: (9 of 10)
(*) Red asterisk indicates a required field.
Medication Reconciliation
Objective: The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
EXCLUSION - Based on ALL patient records: If an EP was not on the receiving end of any transition of care during the EHR reporting period they would be excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
NO
Please select the PREVIOUS PAGE button to go back
PREVIOUS PAGE
SAVE AND CONTINUE
Questionnaire: (9 of 10)
(*) Red asterisk indicates a required field.
Medication Reconciliation
Objective: The EP, eligible hospital or CAH who receives a patient from another setting of care or provider of care or believes an encounter is relevant should perform medication reconciliation
Measure: The EP, eligible hospital or CAH performs medication reconciliation for more than 50% of transitions of care in which the patient is transitioned into the care of the EP or admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23)
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of transitions of care in the denominator where medication reconciliation was performed.
Denominator Number of transitions of care during the EHR reporting period for which the EP was the receiving party of the transition.
*Numerator:
*Denominator:
lease select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

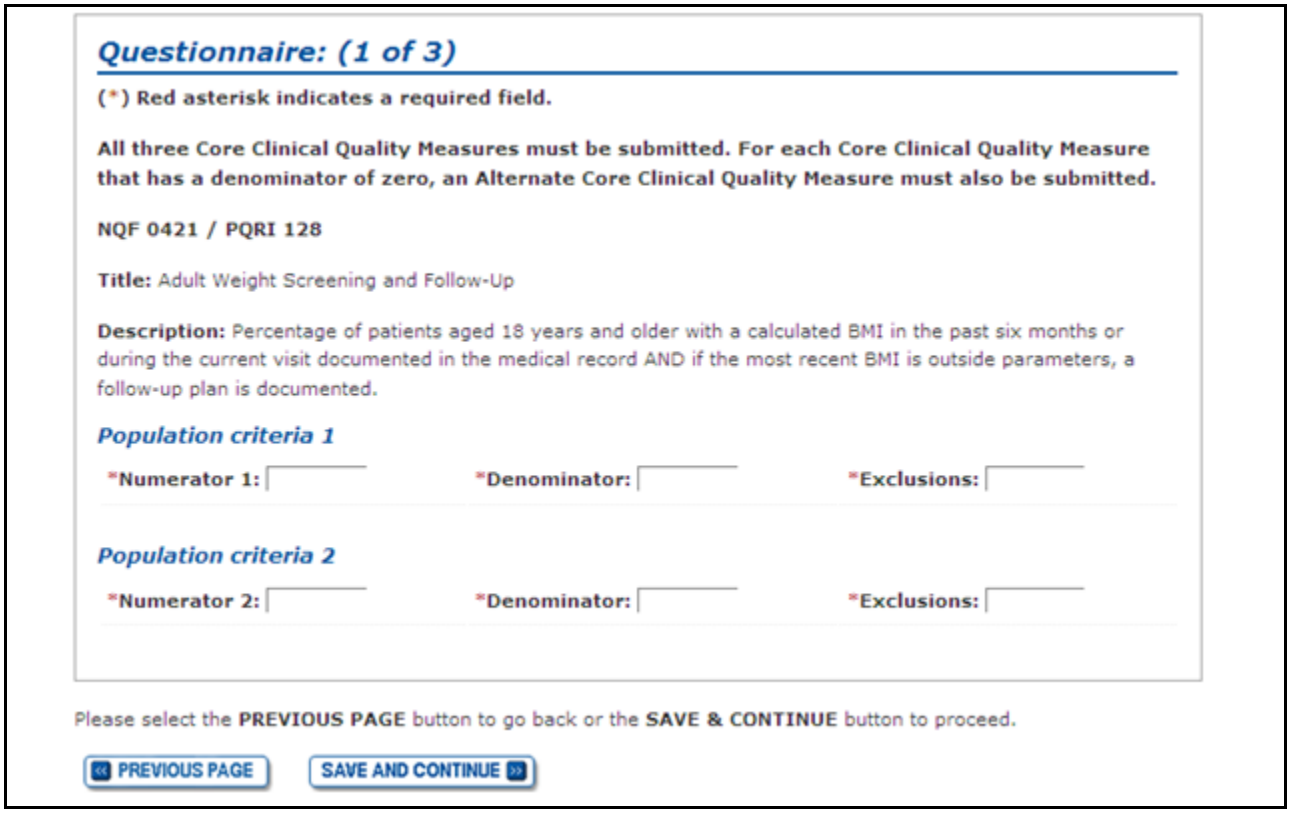
Meaningful Use Menu Measure Question 9 – Medication Reconciliation and answer No to exclusion


Questionnaire: (10 of 10)
(*) Red asterisk indicates a required field.
Transition of Care Summary
Objective: The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral
Measure: The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
EXCLUSION - Based on ALL patient records: If an EP does not transfer a patient to another setting or refer a patient to another provider during the EHR reporting period then they would be excluded from this requirement.
* Does this exclusion apply to you?
Yes
No
NO
Please select the PREVIOUS PAGE button to go back or the
PREVIOUS PAGE
SAVE AND CONTINUE
Questionnaire: (10 of 10)
(*) Red asterisk indicates a required field.
Transition of Care Summary
Objective: The EP, eligible hospital or CAH who transitions their patient to another setting of care or provider of care or refers their patient to another provider of care should provide summary of care record for each transition of care or referral
Measure: The EP, eligible hospital or CAH who transitions or refers their patient to another setting of care or provider of care provides a summary of care record for more than 50% of transitions of care and referrals
Complete the following information. All information entered may be subject to audit that could result in payment recoupment.
Numerator Number of transitions of care and referrals in the denominator where a summary of care record was provided.
Denominator Number of transitions of care and referrals during the EHR reporting period for which the EP was the transferring or referring provider.
*Numerator:
*Denominator:
lease select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

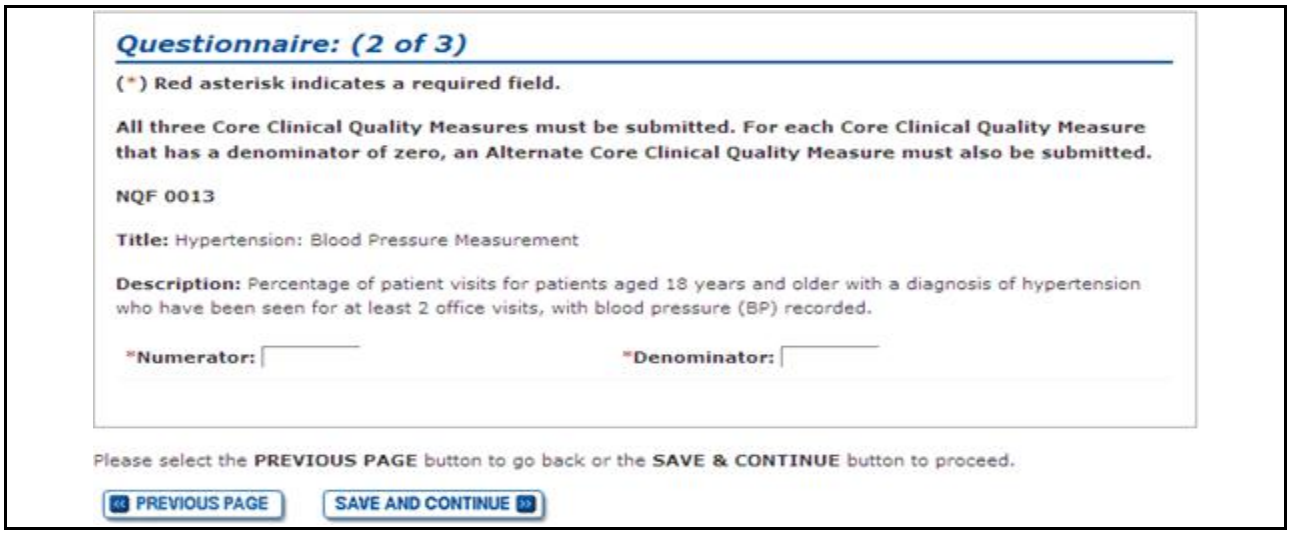
Meaningful Use Menu Measure Question 10 – Transition of Care Summary and answer No to exclusion

30. 2013 ONLY Clinical Quality Measures Screen Shots

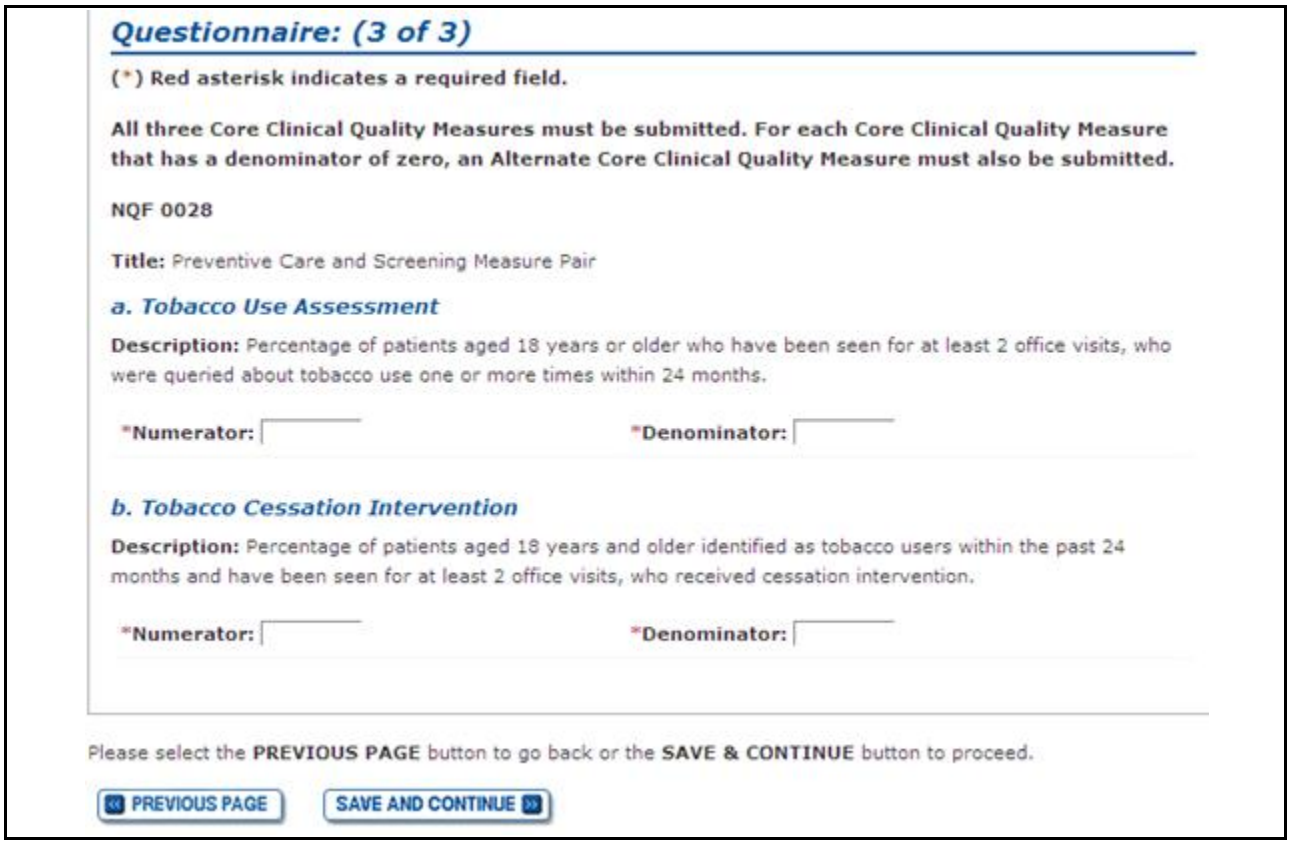
Below are three questions screen shots that are required for response.


Questionnaire: (1 of 3)
(*) Red asterisk indicates a required field.
All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.
NQF 0421 / PQRI 128
Title: Adult Weight Screening and Follow-Up
Description: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
Population criteria 1
*Numerator 1:
*Denominator:
*Exclusions:
Population criteria 2
*Numerator 2:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measures Question 1 – Adult Weight Screening and Follow up

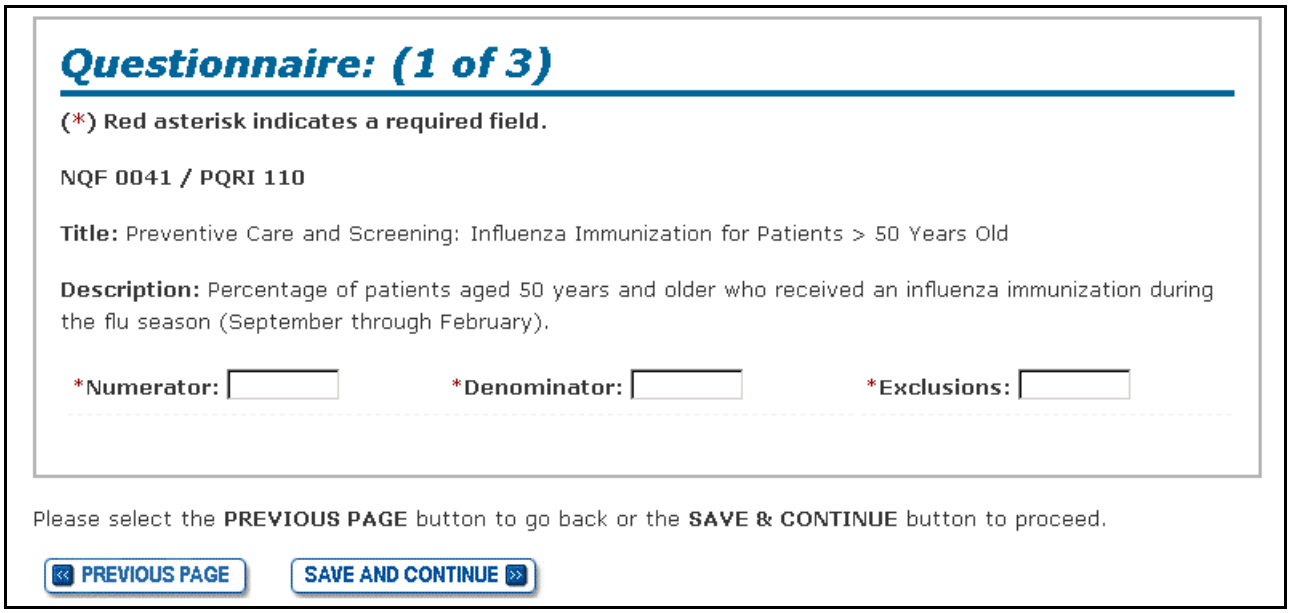

Questionnaire: (2 of 3)
(*) Red asterisk indicates a required field.
All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.
NQF 0013
Title: Hypertension: Blood Pressure Measurement
Description: Percentage of patient visits for patients aged 18 years and older with a diagnosis of hypertension who have been seen for at least 2 office visits, with blood pressure (BP) recorded.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 2 – Hypertension: Blood Pressure Measurement

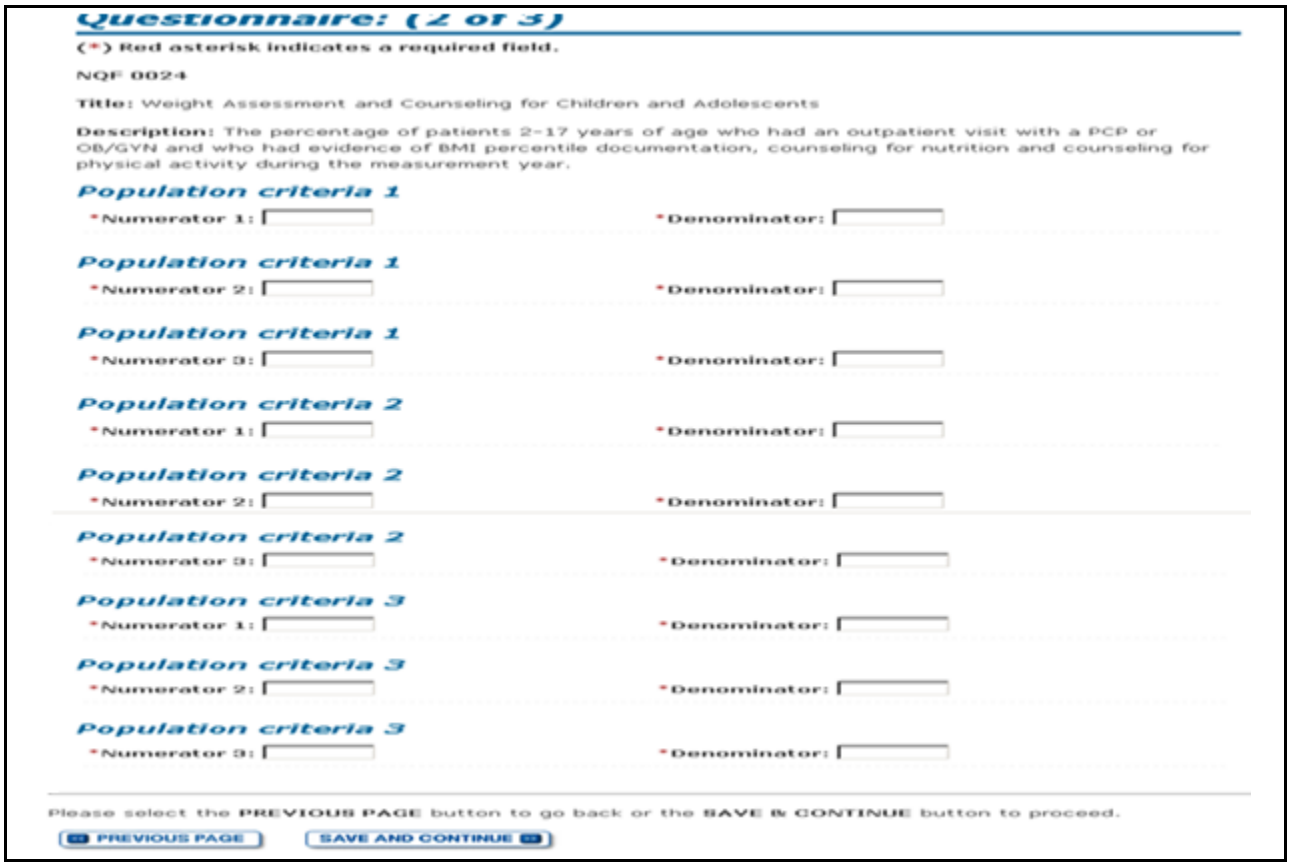

Questionnaire: (3 of 3)
(*) Red asterisk indicates a required field.
All three Core Clinical Quality Measures must be submitted. For each Core Clinical Quality Measure that has a denominator of zero, an Alternate Core Clinical Quality Measure must also be submitted.
NQF 0028
Title: Preventive Care and Screening Measure Pair
a. Tobacco Use Assessment
Description: Percentage of patients aged 18 years or older who have been seen for at least 2 office visits, who were queried about tobacco use one or more times within 24 months.
*Numerator:
*Denominator:
b. Tobacco Cessation Intervention
Description: Percentage of patients aged 18 years and older identified as tobacco users within the past 24 months and have been seen for at least 2 office visits, who received cessation intervention.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 3 – Preventive Care and Screening Measure Pair

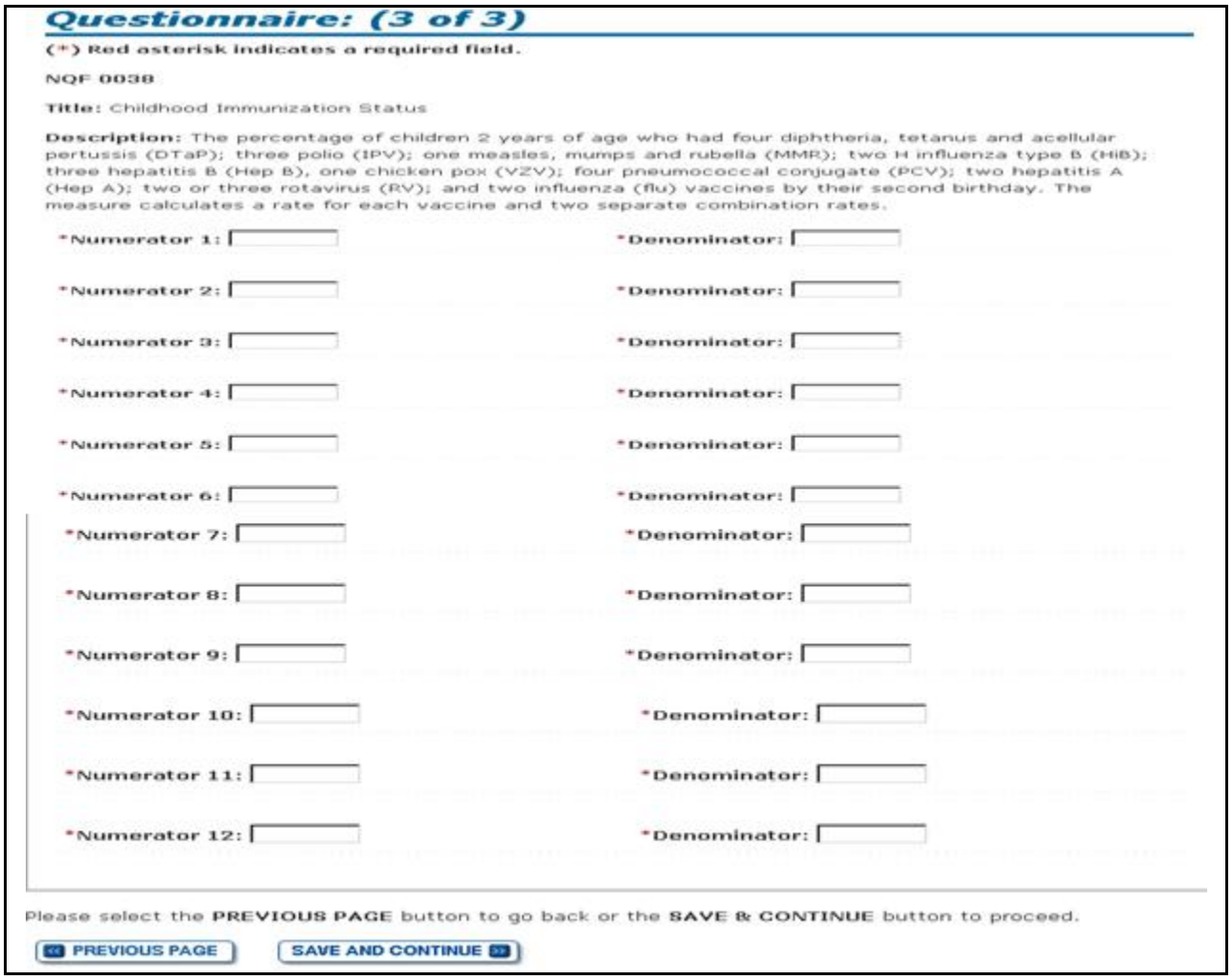
If the denominator of the questions above is zero, then the following questions will require response. Below are the screen shots for the questions.


Questionnaire: (1 of 3)
(*) Red asterisk indicates a required field.
NQF 0041 / PQRI 110
Title: Preventive Care and Screening: Influenza Immunization for Patients > 50 Years Old
Description: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 1 if denominator is 0- Preventive Care and Screening: Influenza Immunization for Patients > 50 years old

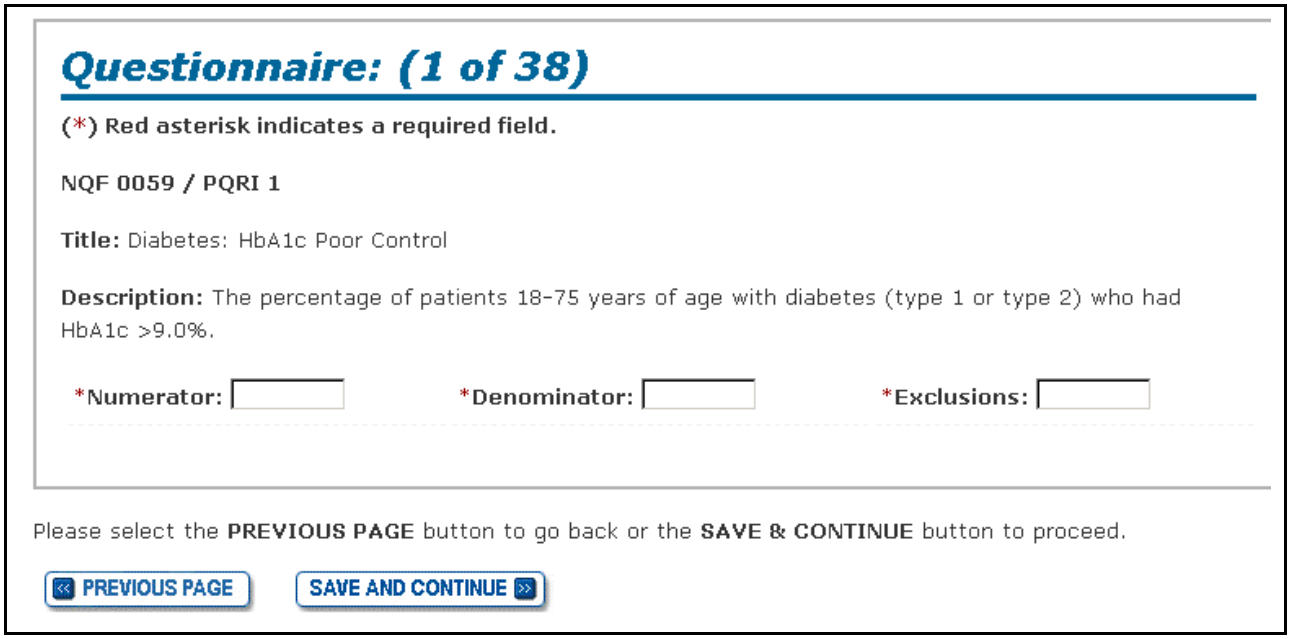


Clinical Quality Measure Question 2 if denominator is 0 – Weight Assessment and Counseling for Children and Adolescents

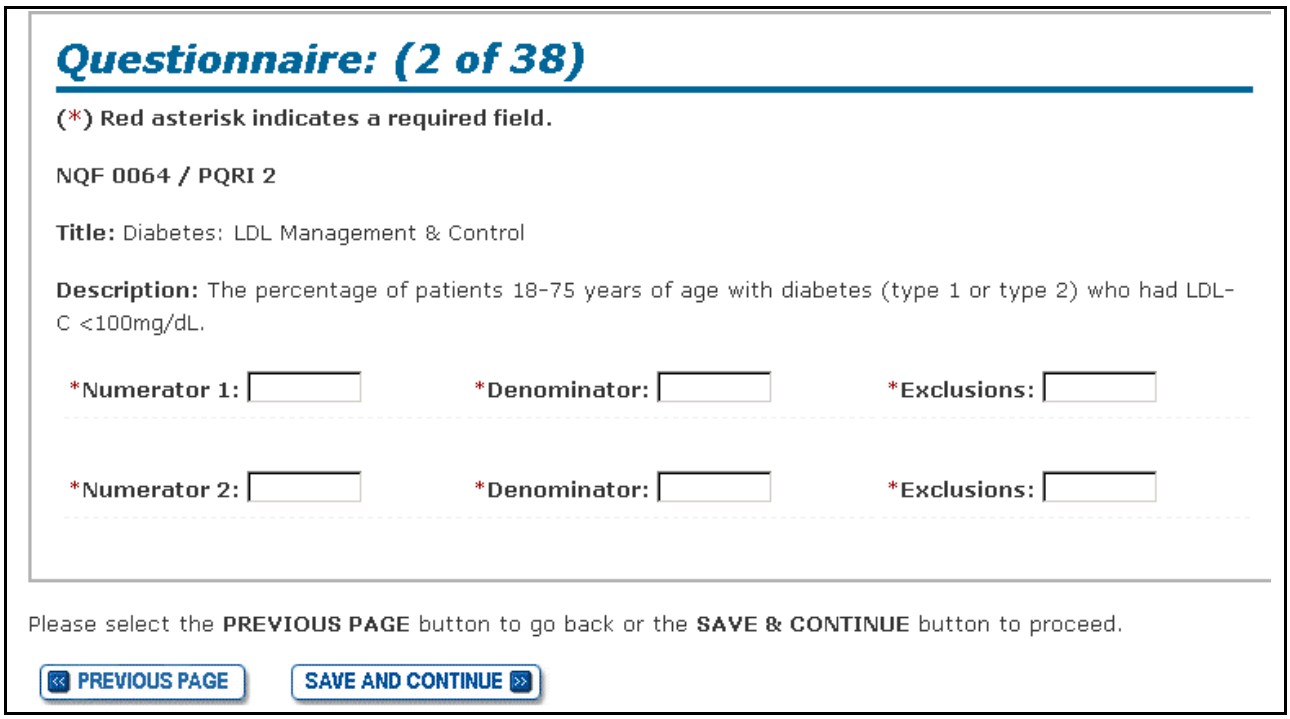

Questionnaire: (3 of 3)
(*) Red asterisk indicates a required field.
NQF 0038
Title: Childhood Immunization Status
Description: The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); two H influenza type B (HiB); three hepatitis B (Hep B), one chicken pox (VZV); four pneumococcal conjugate (PCV); two hepatitis A (Hep A); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.
*Numerator 1:
*Denominator:
*Numerator 2:
*Denominator:
*Numerator 3:
*Denominator:
*Numerator 4:
*Denominator:
*Numerator 5:
*Denominator:
*Numerator 6:
*Denominator:
*Numerator 7:
*Denominator:
*Numerator 8:
*Denominator:
*Numerator 9:
*Denominator:
*Numerator 10:
*Denominator:
*Numerator 11:
*Denominator:
*Numerator 12:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 3 if denominator is 0 – Childhood Immunization Status

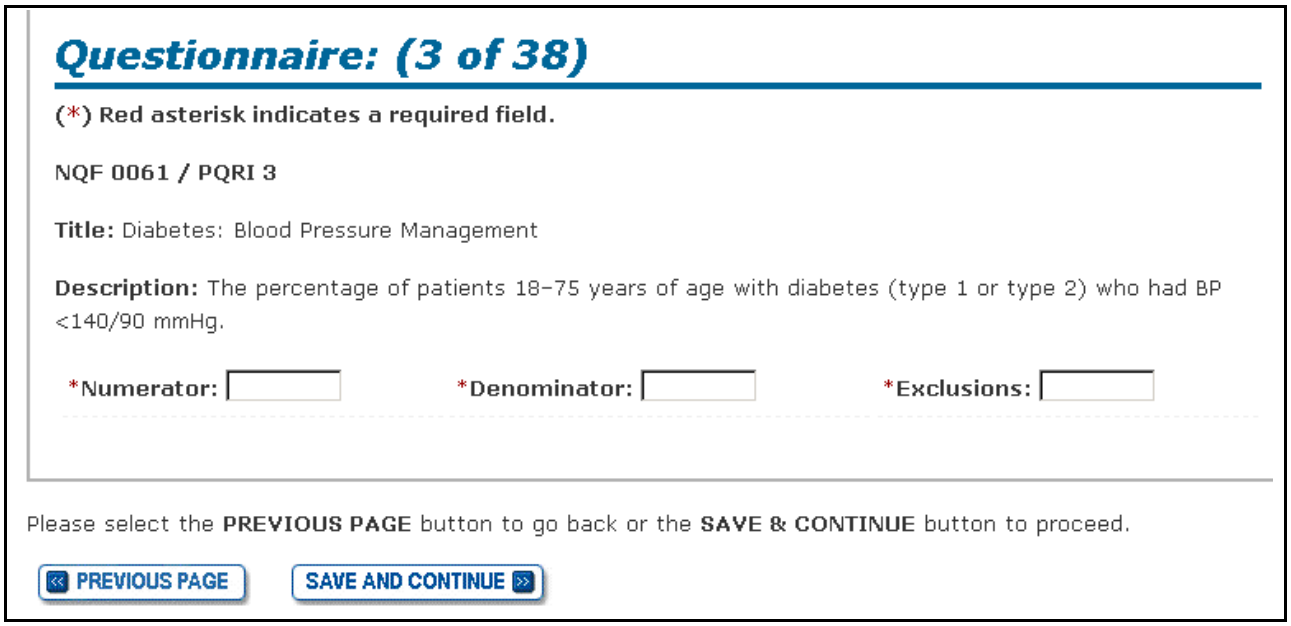
The following 38 screen shots are available for selection. To meet CMS requirements, three questions must be selected.


Questionnaire: (1 of 38)
(*) Red asterisk indicates a required field.
NQF 0059 / PQRI 1
Title: Diabetes: HbA1c Poor Control
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c >9.0%.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

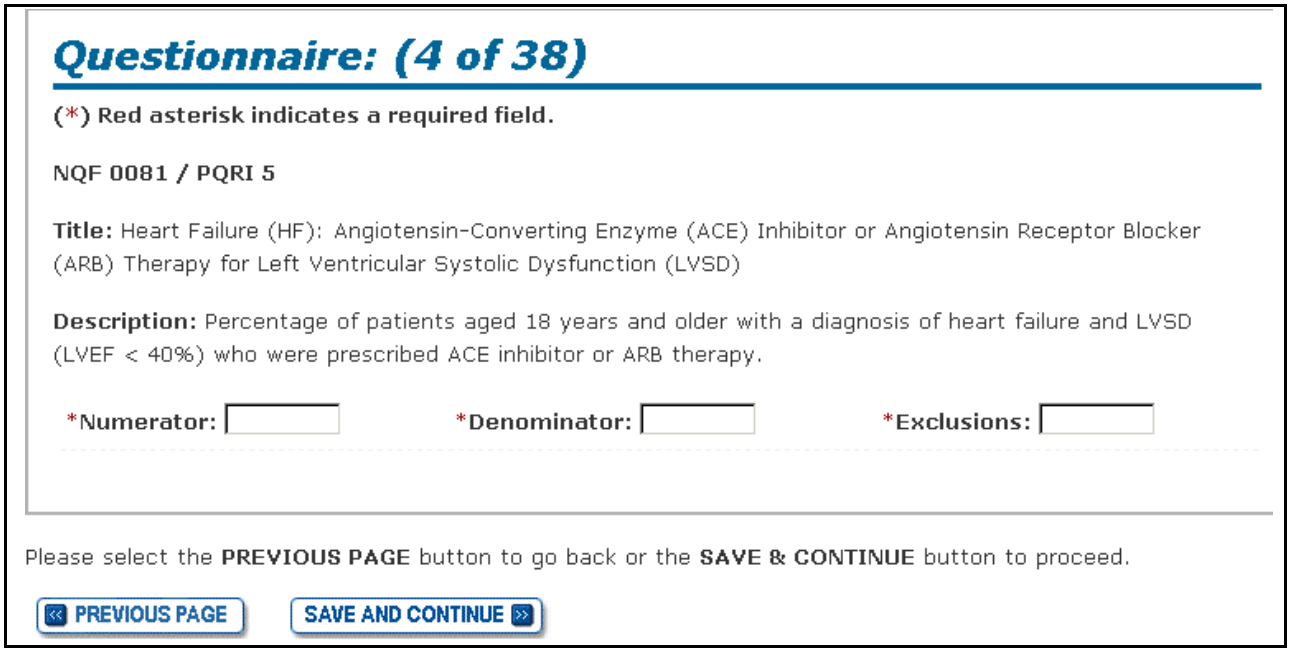
Clinical Quality Measure Question 1 – Diabetes: HbA1c Poor Control


Questionnaire: (2 of 38)
(*) Red asterisk indicates a required field.
NQF 0064 / PQRI 2
Title: Diabetes: LDL Management & Control
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had LDL-C <100mg/dL.
*Numerator 1:
*Denominator:
*Exclusions:
*Numerator 2:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

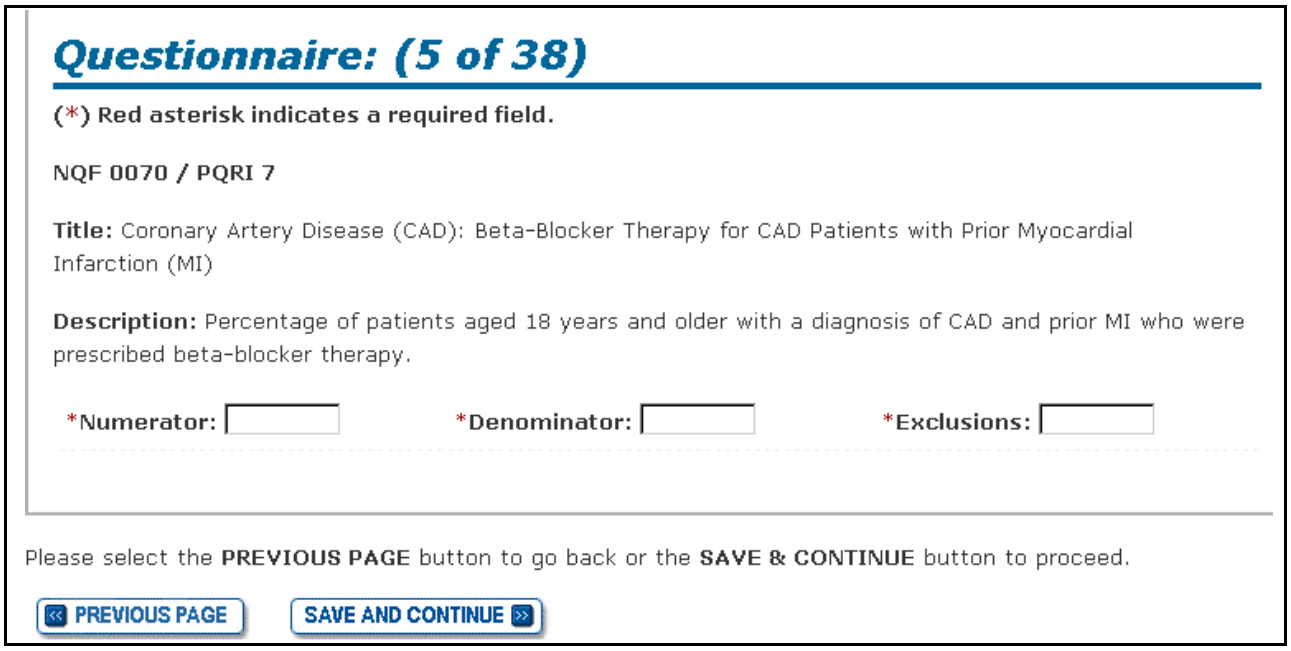
Clinical Quality Measure Question 2 – Diabetes: LDL Management & Control


Questionnaire: (3 of 38)
(*) Red asterisk indicates a required field.
NQF 0061 / PQRI 3
Title: Diabetes: Blood Pressure Management
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had BP <140/90 mmHg.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

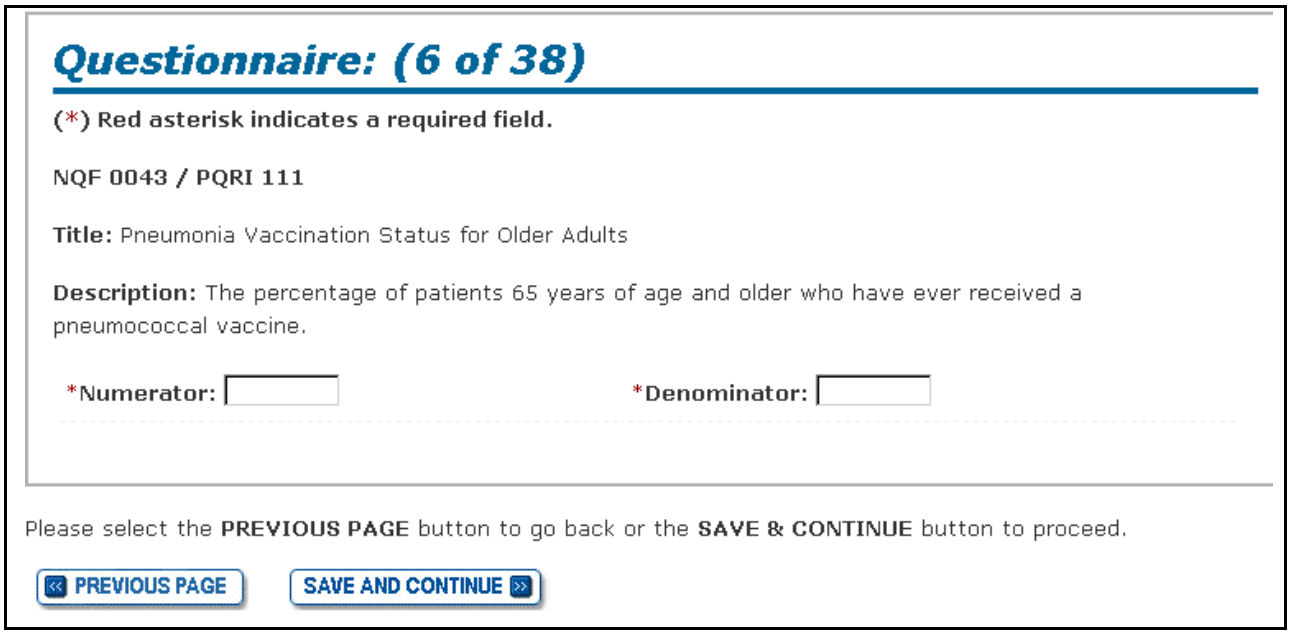
Clinical Quality Measure Question 3 – Diabetes: Blood Pressure Management


Questionnaire: (4 of 38)
(*) Red asterisk indicates a required field.
NQF 0081 / PQRI 5
Title: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

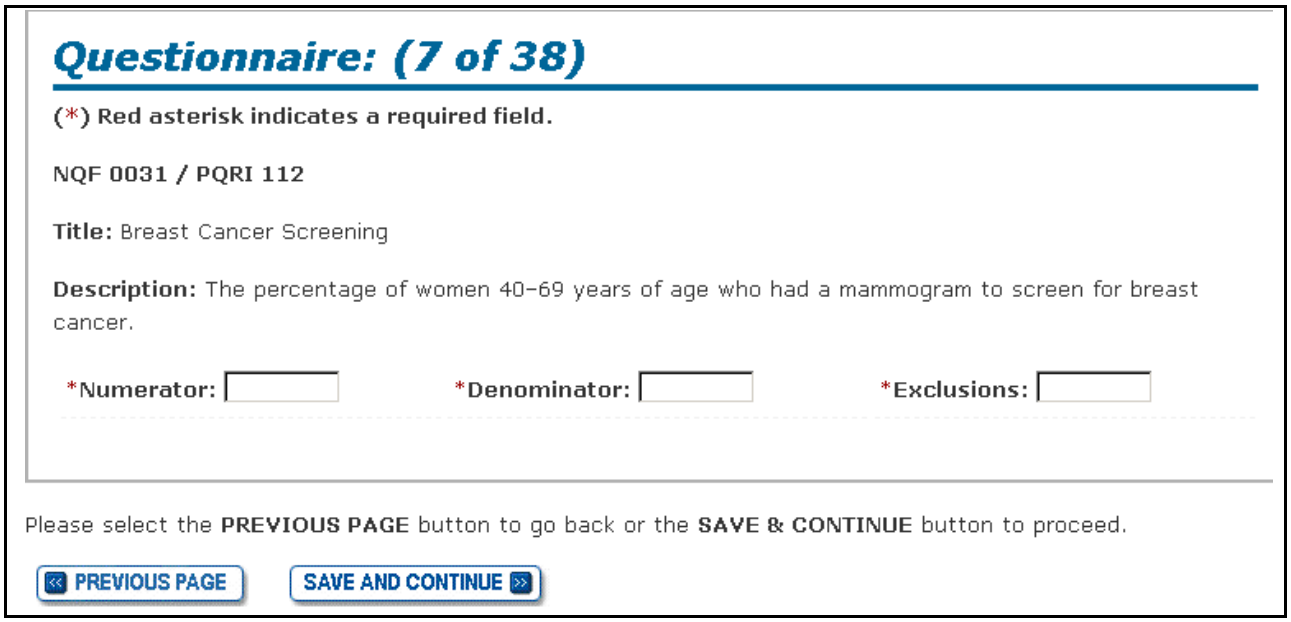
Clinical Quality Measure Question 4 – HF: ACE Inhibitor or ARB for LVSD


Questionnaire: (5 of 38)
(*) Red asterisk indicates a required field.
NQF 0070 / PQRI 7
Title: Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

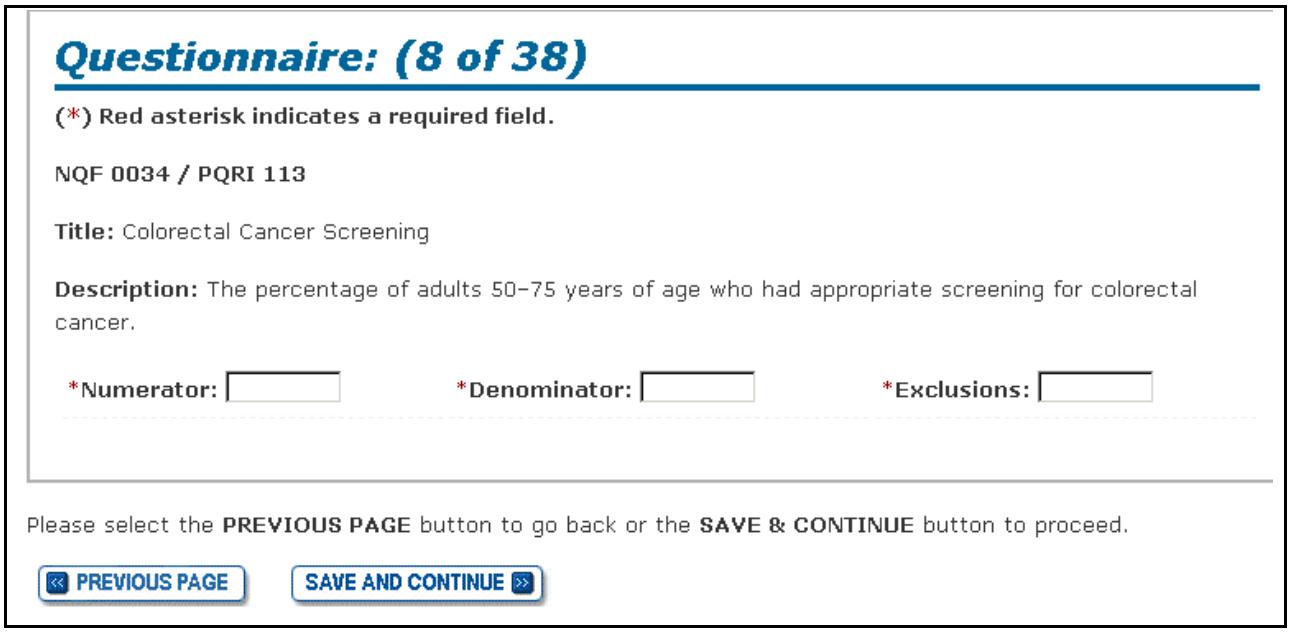
Clinical Quality Measure Question 5 – CAD: Beta-blocker Therapy for CAD patients with MI


Questionnaire: (6 of 38)
(*) Red asterisk indicates a required field.
NQF 0043 / PQRI 111
Title: Pneumonia Vaccination Status for Older Adults
Description: The percentage of patients 65 years of age and older who have ever received a pneumococcal vaccine.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

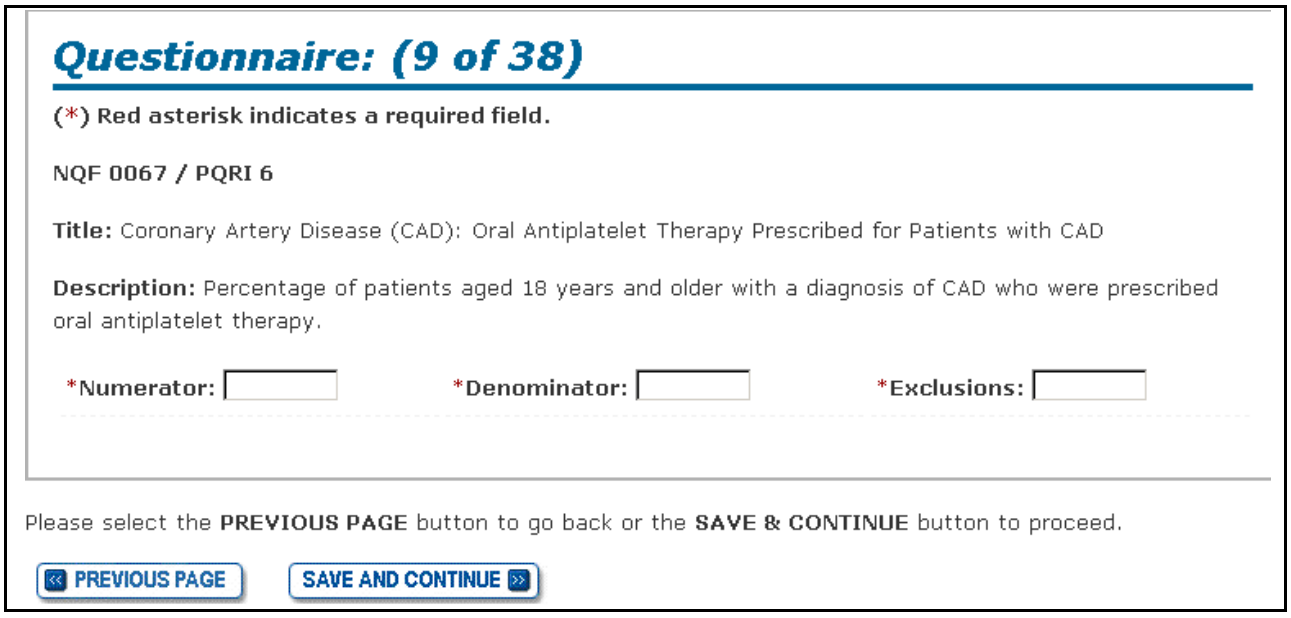
Clinical Quality Measure Question 6 – Pneumonia Vaccination Status for Older Adults


Questionnaire: (7 of 38)
(*) Red asterisk indicates a required field.
NQF 0031 / PQRI 112
Title: Breast Cancer Screening
Description: The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

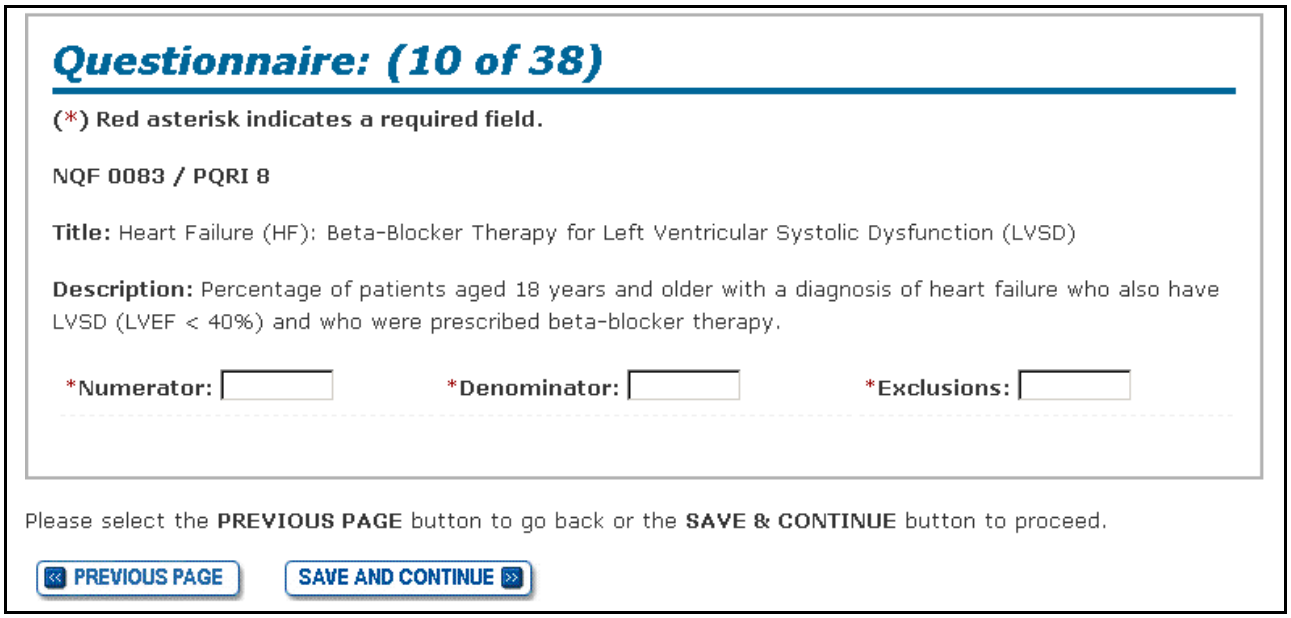
Clinical Quality Measure Question 7 – Breast Cancer Screening


Questionnaire: (8 of 38)
(*) Red asterisk indicates a required field.
NQF 0034 / PQRI 113
Title: Colorectal Cancer Screening
Description: The percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

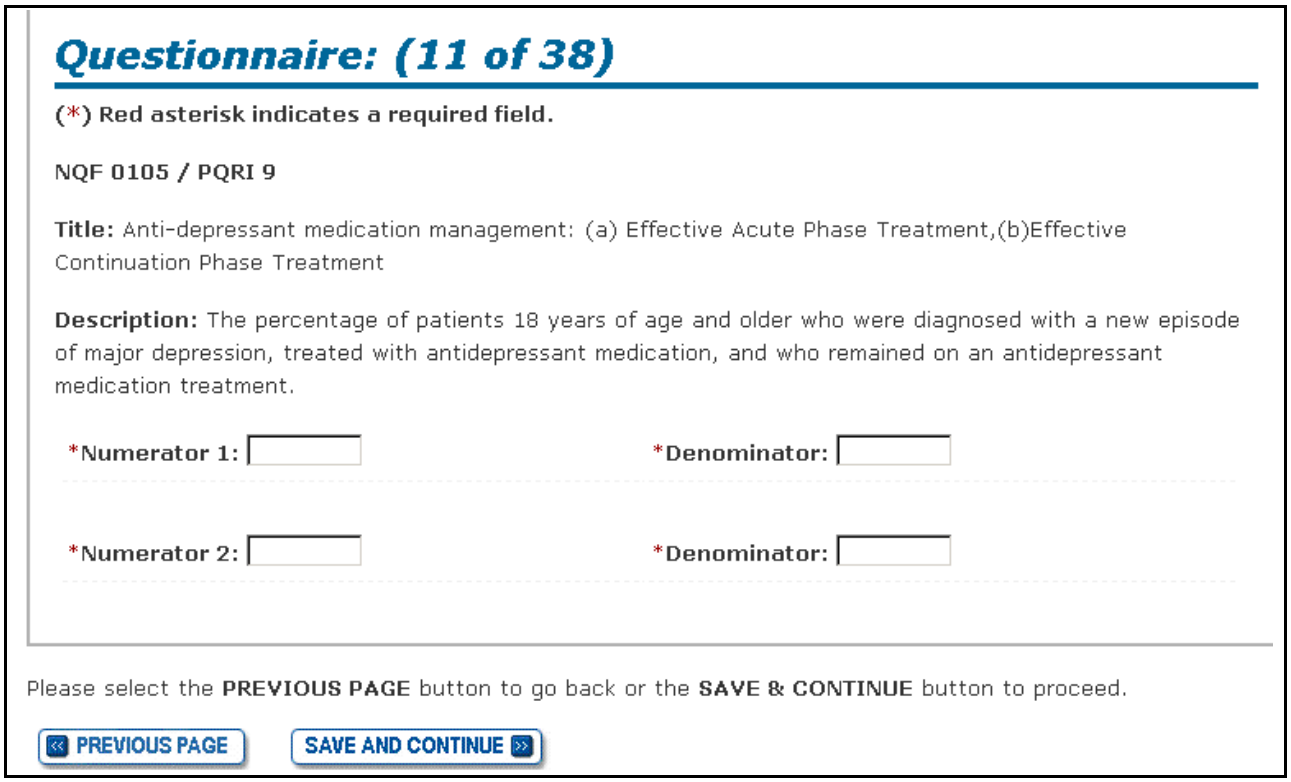
Clinical Quality Measure Question 8 – Colorectal Cancer Screening


Questionnaire: (9 of 38)
(*) Red asterisk indicates a required field.
NQF 0067 / PQRI 6
Title: Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

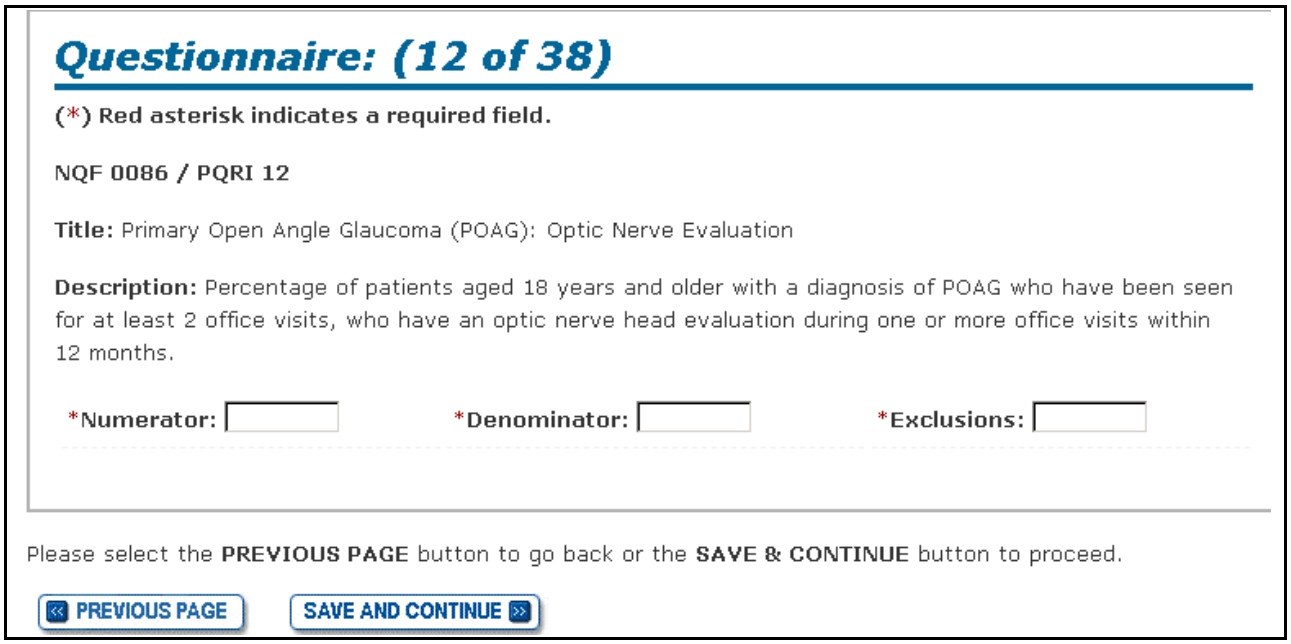
Clinical Quality Measure Question 9 – CAD: Oral Antiplatelet Therapy


Questionnaire: (10 of 38)
(*) Red asterisk indicates a required field.
NQF 0083 / PQRI 8
Title: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
Description: Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

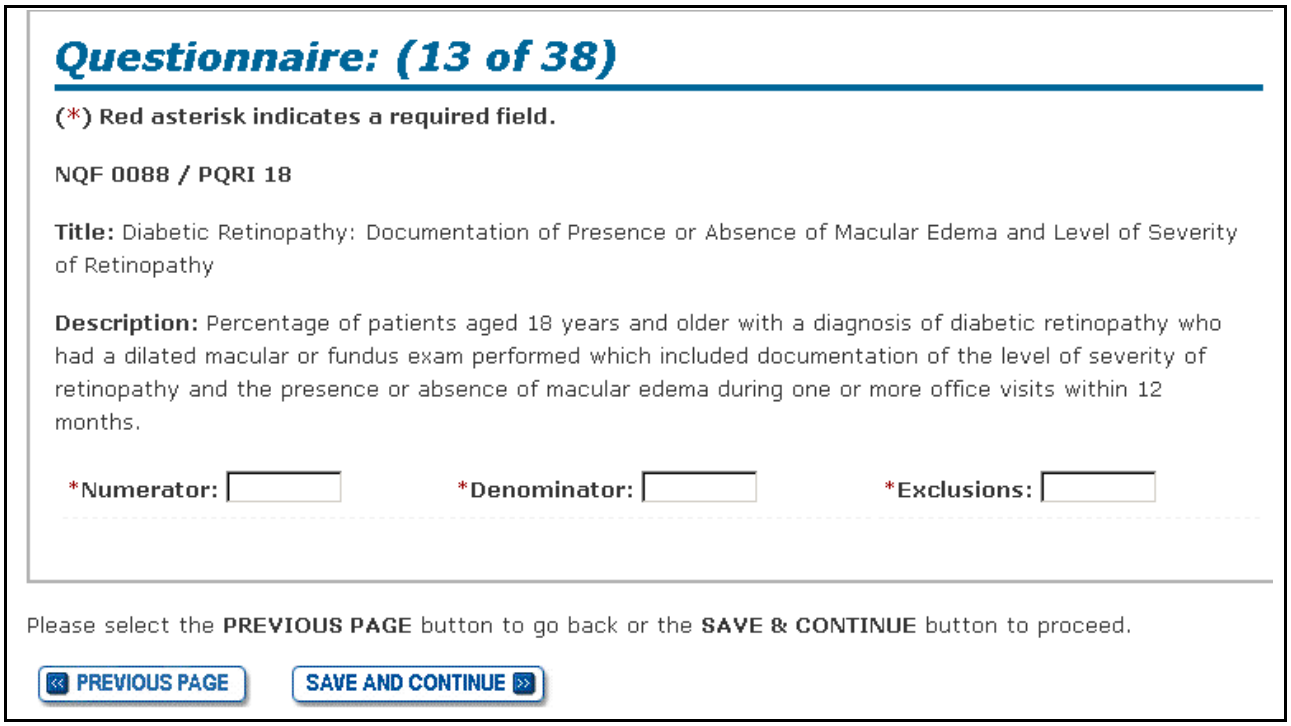
Clinical Quality Measure Question 10 – HF: Beta-blocker Therapy for LVSD


Questionnaire: (11 of 38)
(*) Red asterisk indicates a required field.
NQF 0105 / PQRI 9
Title: Anti-depressant medication management: (a) Effective Acute Phase Treatment,(b)Effective Continuation Phase Treatment
Description: The percentage of patients 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment.
*Numerator 1:
*Denominator:
*Numerator 2:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

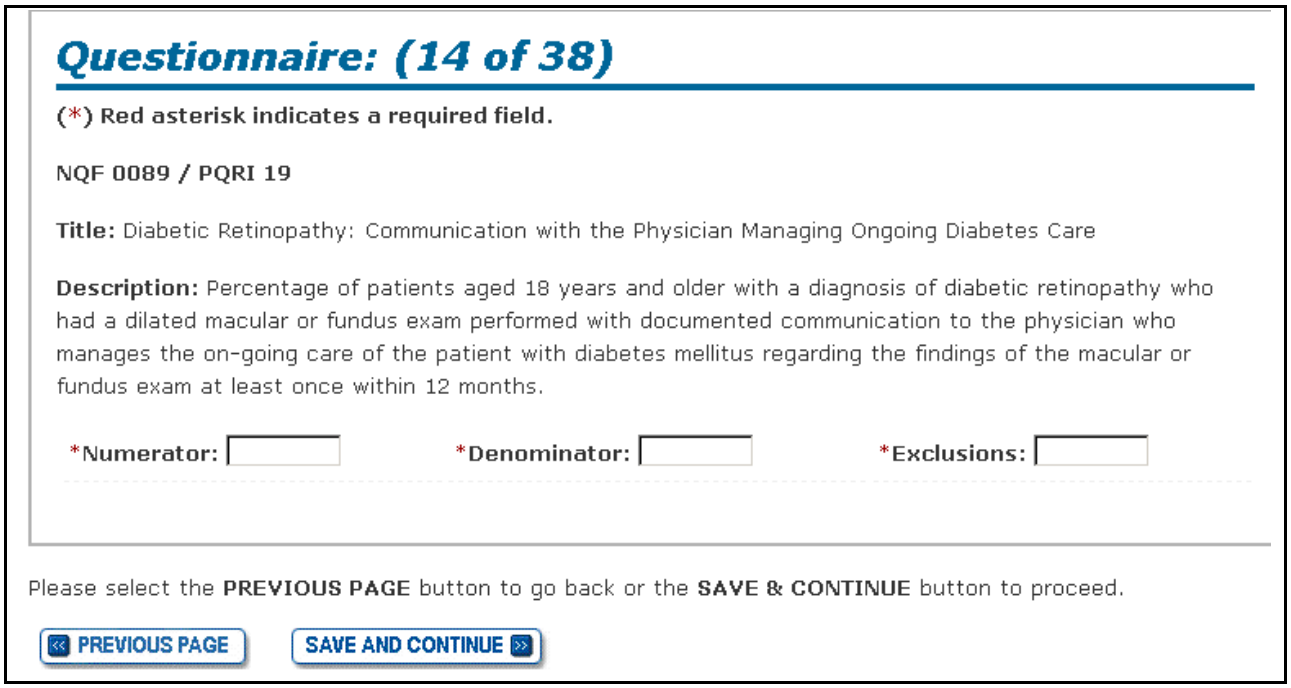
Clinical Quality Measure Question 11 – Anti-depressant medication management


Questionnaire: (12 of 38)
(*) Red asterisk indicates a required field.
NQF 0086 / PQRI 12
Title: Primary Open Angle Glaucoma (POAG): Optic Nerve Evaluation
Description: Percentage of patients aged 18 years and older with a diagnosis of POAG who have been seen for at least 2 office visits, who have an optic nerve head evaluation during one or more office visits within 12 months.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

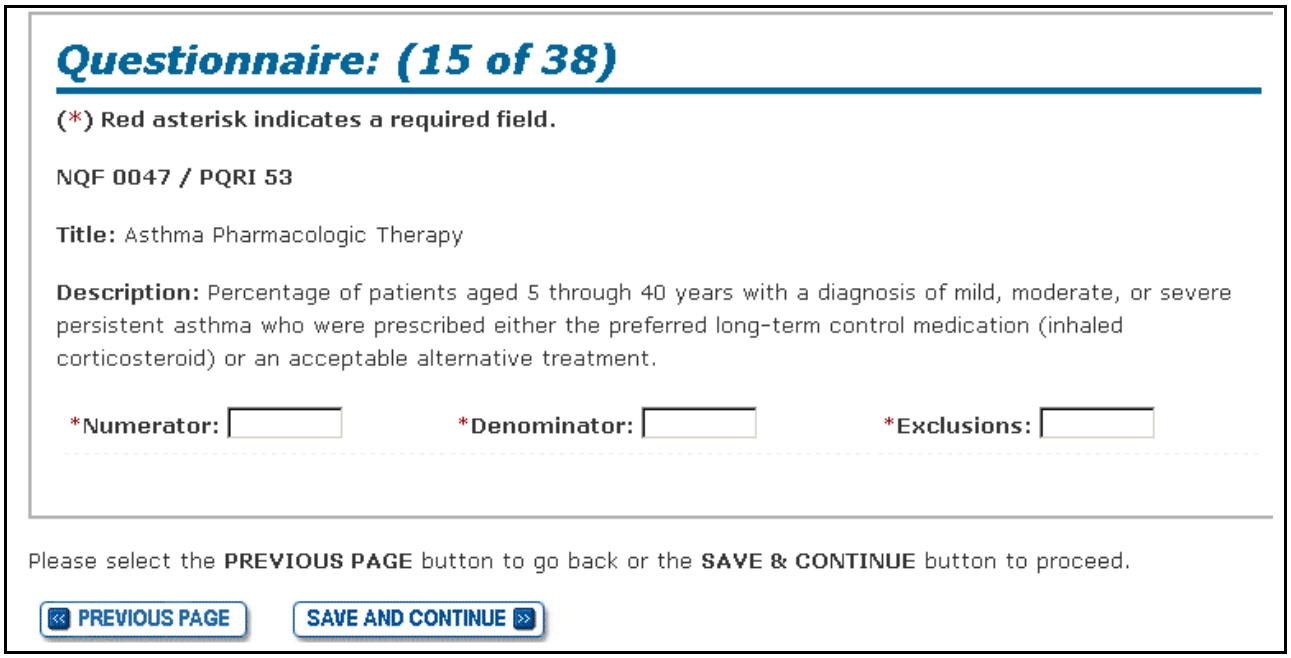
Clinical Quality Measure Question 12 – POAG: Optic Nerve Evaluation


Questionnaire: (13 of 38)
(*) Red asterisk indicates a required field.
NQF 0088 / PQRI 18
Title: Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed which included documentation of the level of severity of retinopathy and the presence or absence of macular edema during one or more office visits within 12 months.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

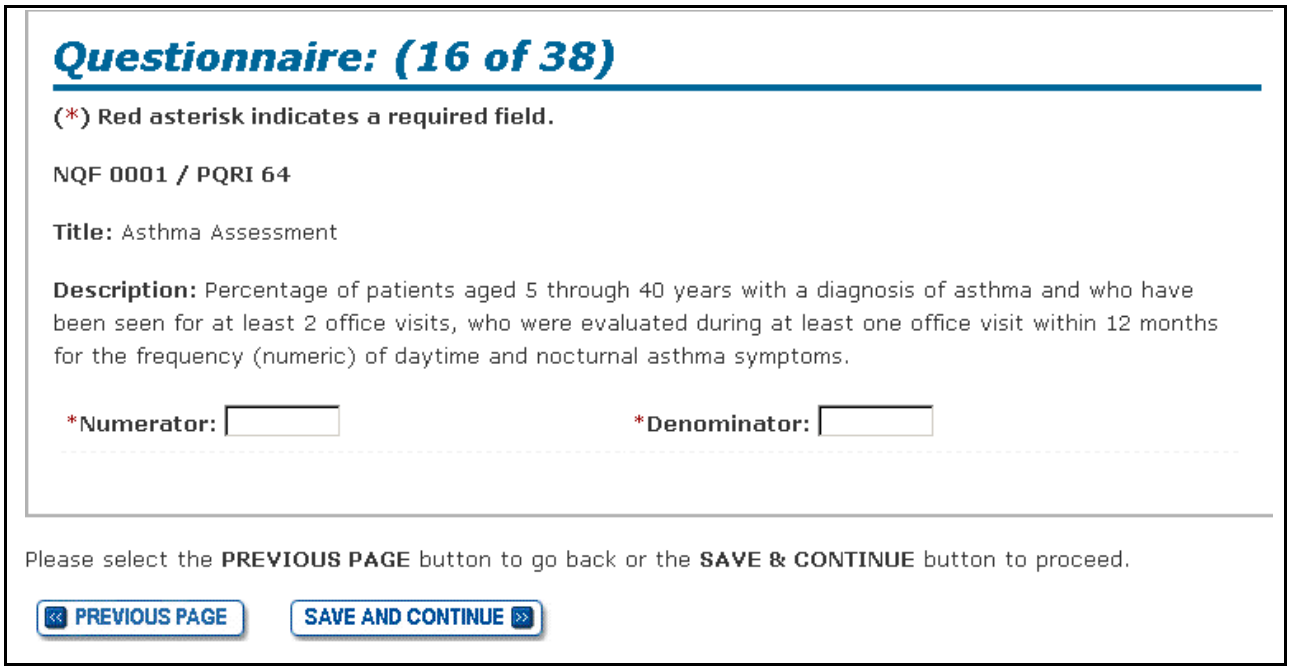
Clinical Quality Measure Question 13 – Diabetic Retinopathy: Documentation


Questionnaire: (14 of 38)
(*) Red asterisk indicates a required field.
NQF 0089 / PQRI 19
Title: Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care
Description: Percentage of patients aged 18 years and older with a diagnosis of diabetic retinopathy who had a dilated macular or fundus exam performed with documented communication to the physician who manages the on-going care of the patient with diabetes mellitus regarding the findings of the macular or fundus exam at least once within 12 months.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

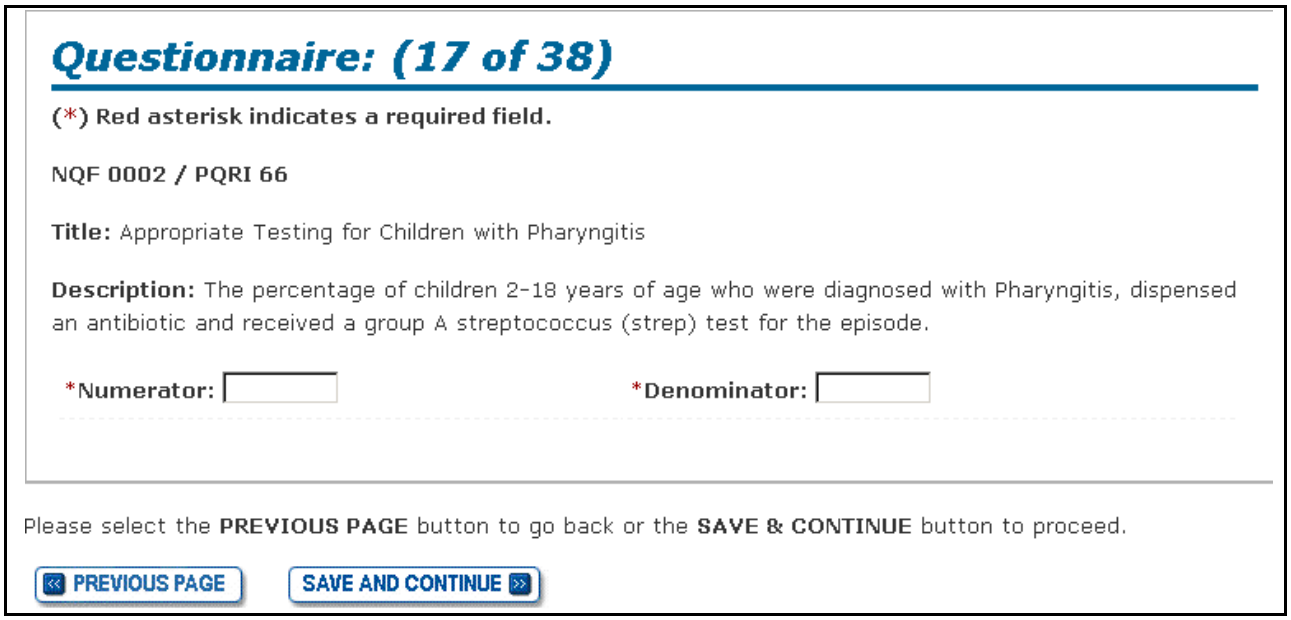
Clinical Quality Measure Question 14 – Diabetic Retinopathy: Communication


Questionnaire: (15 of 38)
(*) Red asterisk indicates a required field.
NQF 0047 / PQRI 53
Title: Asthma Pharmacologic Therapy
Description: Percentage of patients aged 5 through 40 years with a diagnosis of mild, moderate, or severe persistent asthma who were prescribed either the preferred long-term control medication (inhaled corticosteroid) or an acceptable alternative treatment.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

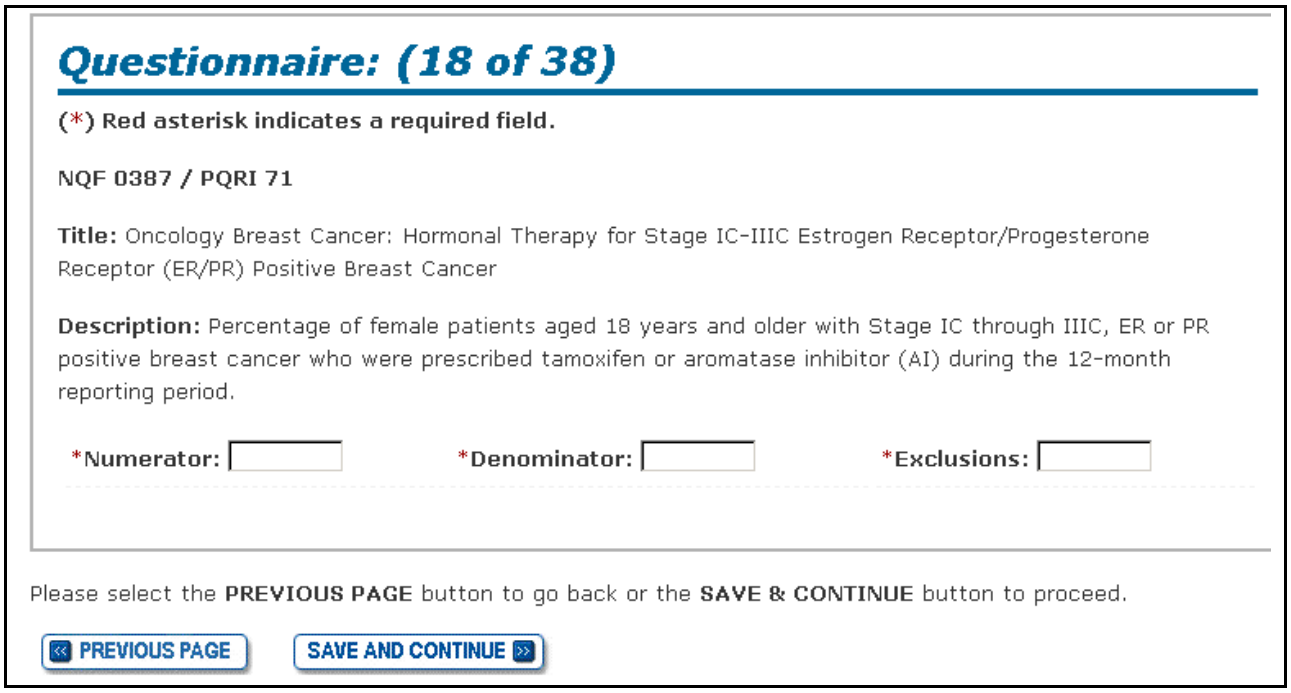
Clinical Quality Measure Question 15 – Asthma Pharmacologic Therapy


Questionnaire: (16 of 38)
(*) Red asterisk indicates a required field.
NQF 0001 / PQRI 64
Title: Asthma Assessment
Description: Percentage of patients aged 5 through 40 years with a diagnosis of asthma and who have been seen for at least 2 office visits, who were evaluated during at least one office visit within 12 months for the frequency (numeric) of daytime and nocturnal asthma symptoms.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

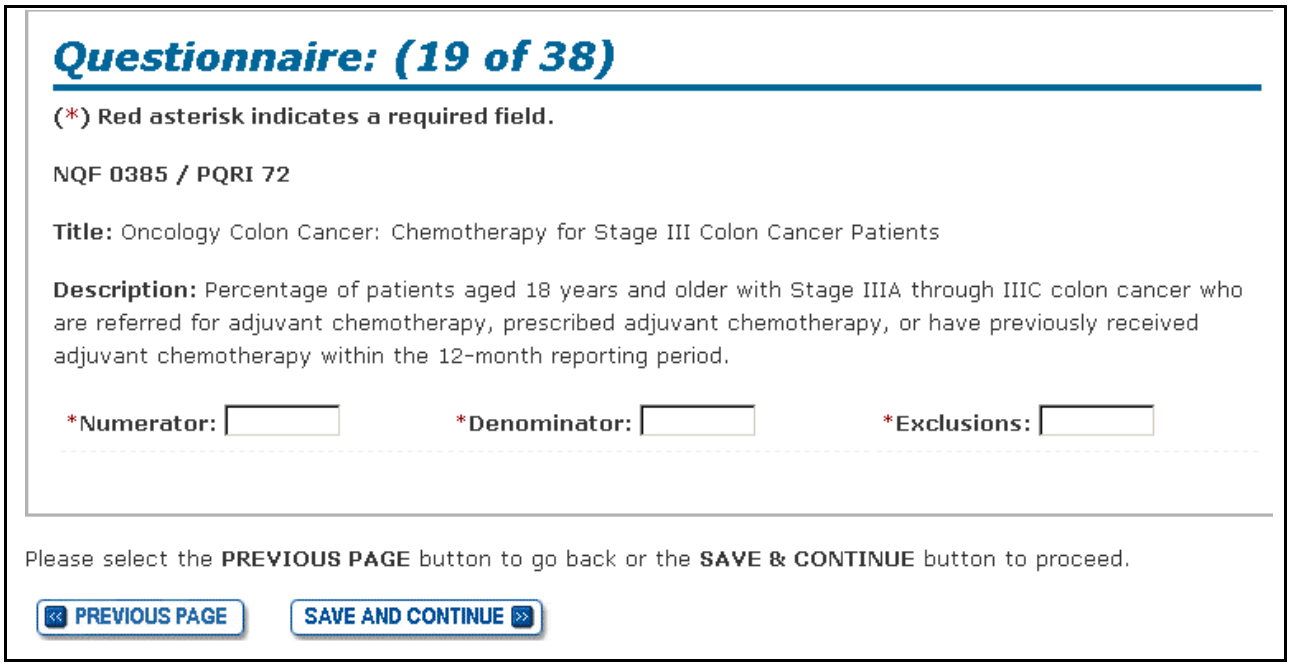
Clinical Quality Measure Question 16 – Asthma Assessment


Questionnaire: (17 of 38)
(*) Red asterisk indicates a required field.
NQF 0002 / PQRI 66
Title: Appropriate Testing for Children with Pharyngitis
Description: The percentage of children 2-18 years of age who were diagnosed with Pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

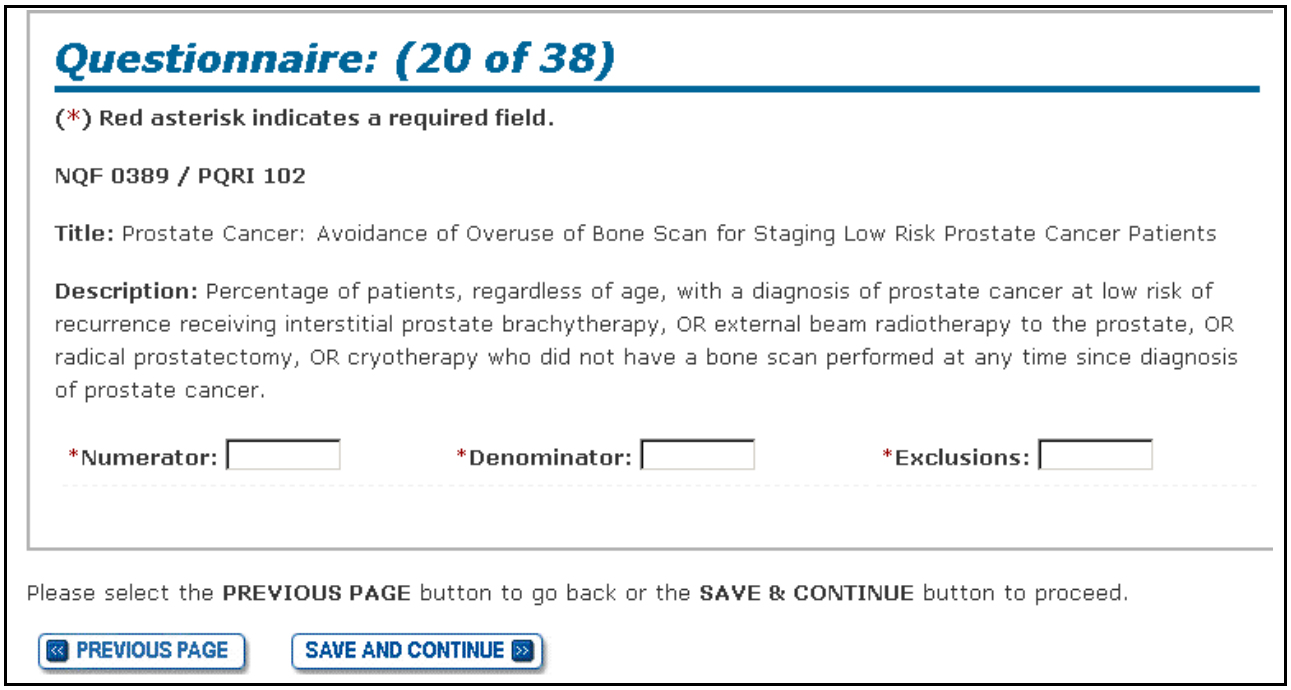
Clinical Quality Measure Question 17 – Appropriate Testing for Children for Pharyngitis


Questionnaire: (18 of 38)
(*) Red asterisk indicates a required field.
NQF 0387 / PQRI 71
Title: Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer
Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, ER or PR positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12-month reporting period.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

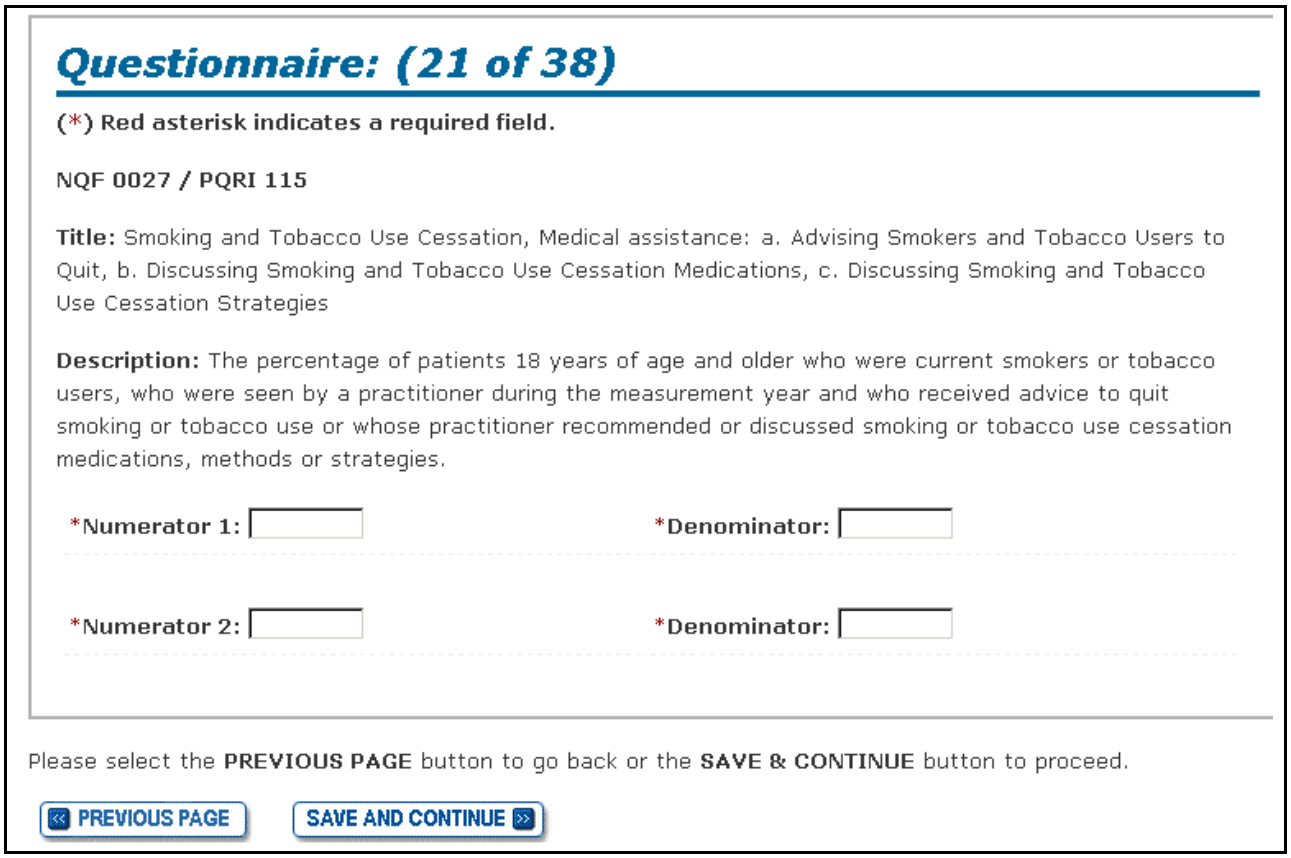
Clinical Quality Measure Question 18 – Oncology Breast Cancer: Hormonal Therapy for Stage IC-IIIC


Questionnaire: (19 of 38)
(*) Red asterisk indicates a required field.
NQF 0385 / PQRI 72
Title: Oncology Colon Cancer: Chemotherapy for Stage III Colon Cancer Patients
Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12-month reporting period.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

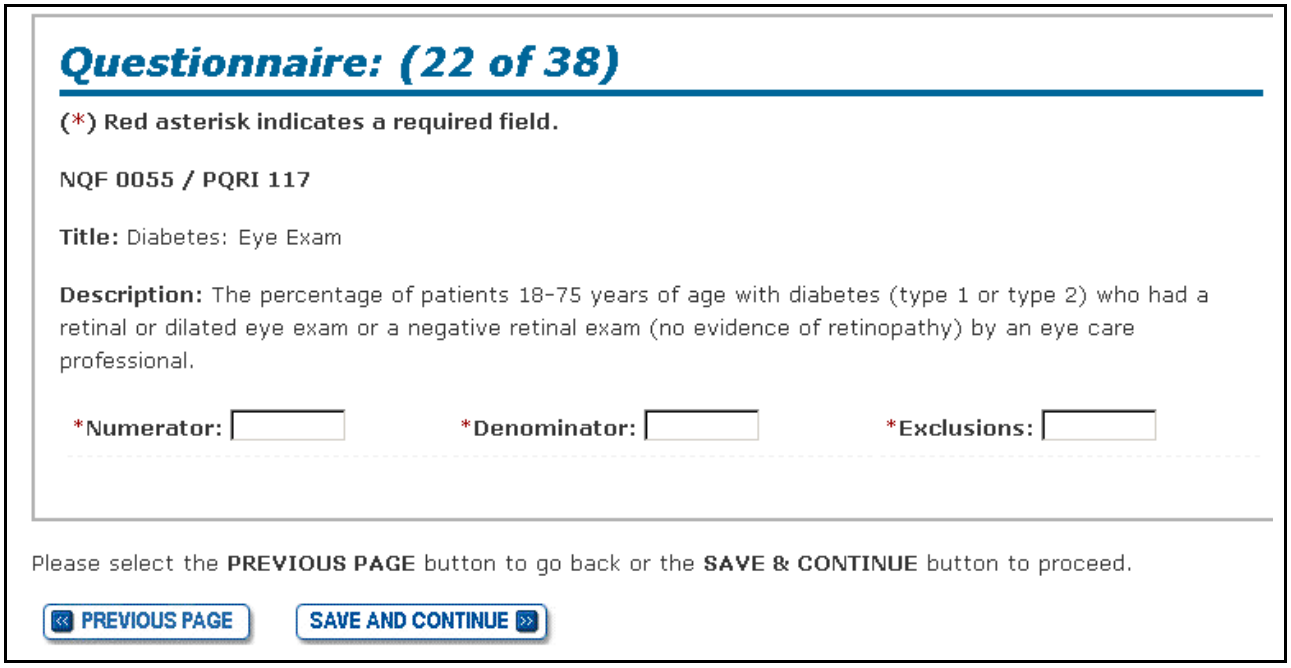
Clinical Quality Measure Question 19 – Oncology Colon Cancer: Chemotherapy for Stage III


Questionnaire: (20 of 38)
(*) Red asterisk indicates a required field.
NQF 0389 / PQRI 102
Title: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

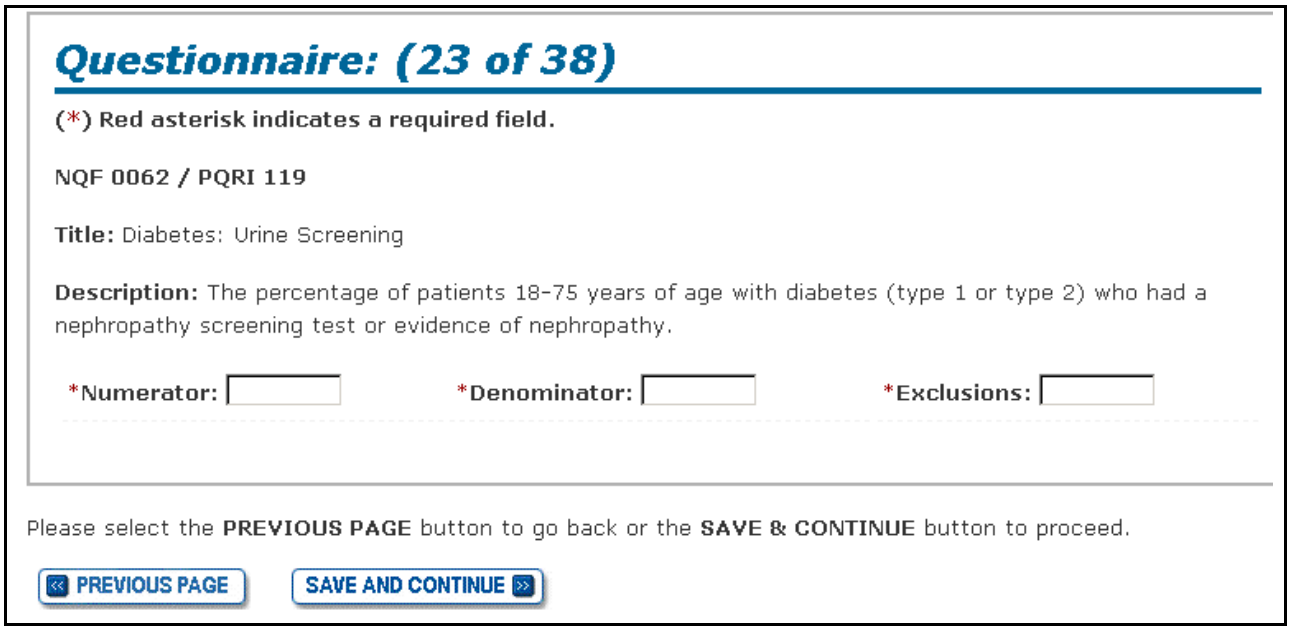
Clinical Quality Measure Question 20 – Prostate Cancer: Avoidance of Overuse of Bone Scan


Questionnaire: (21 of 38)
(*) Red asterisk indicates a required field.
NQF 0027 / PQRI 115
Title: Smoking and Tobacco Use Cessation, Medical assistance: a. Advising Smokers and Tobacco Users to Quit, b. Discussing Smoking and Tobacco Use Cessation Medications, c. Discussing Smoking and Tobacco Use Cessation Strategies
Description: The percentage of patients 18 years of age and older who were current smokers or tobacco users, who were seen by a practitioner during the measurement year and who received advice to quit smoking or tobacco use or whose practitioner recommended or discussed smoking or tobacco use cessation medications, methods or strategies.
*Numerator 1:
*Denominator:
*Numerator 2:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

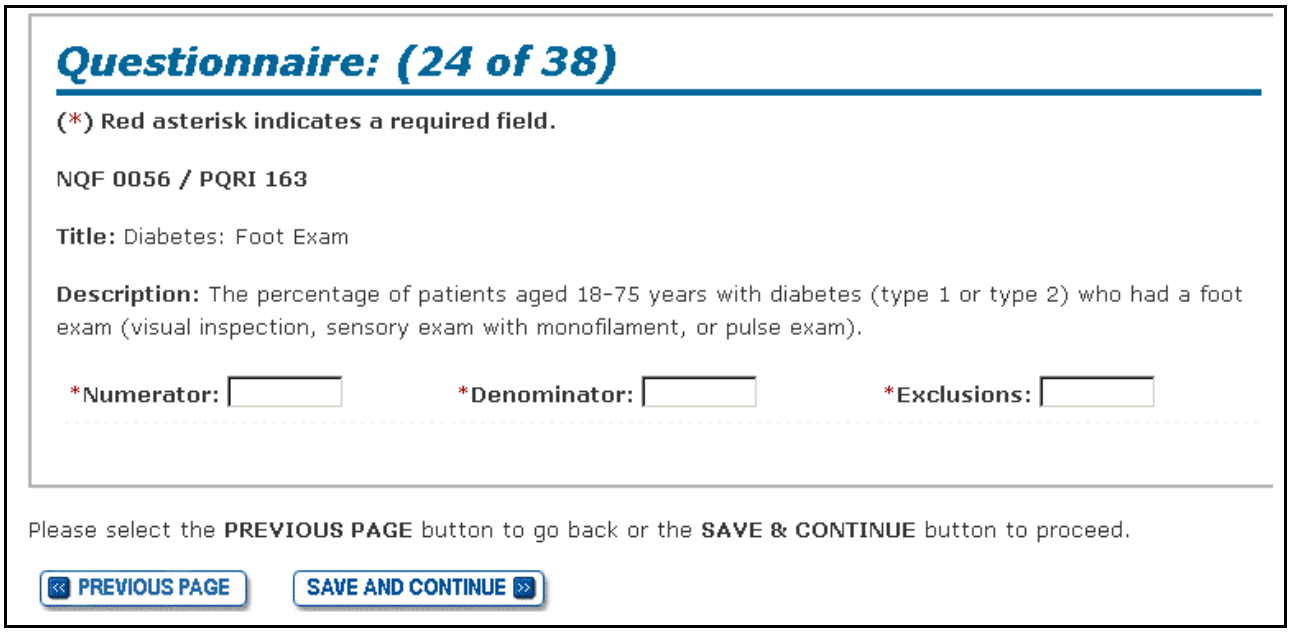
Clinical Quality Measures Question 21 – Smoking & Tobacco Use Cessation, Medical assistance


Questionnaire: (22 of 38)
(*) Red asterisk indicates a required field.
NQF 0055 / PQRI 117
Title: Diabetes: Eye Exam
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a retinal or dilated eye exam or a negative retinal exam (no evidence of retinopathy) by an eye care professional.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

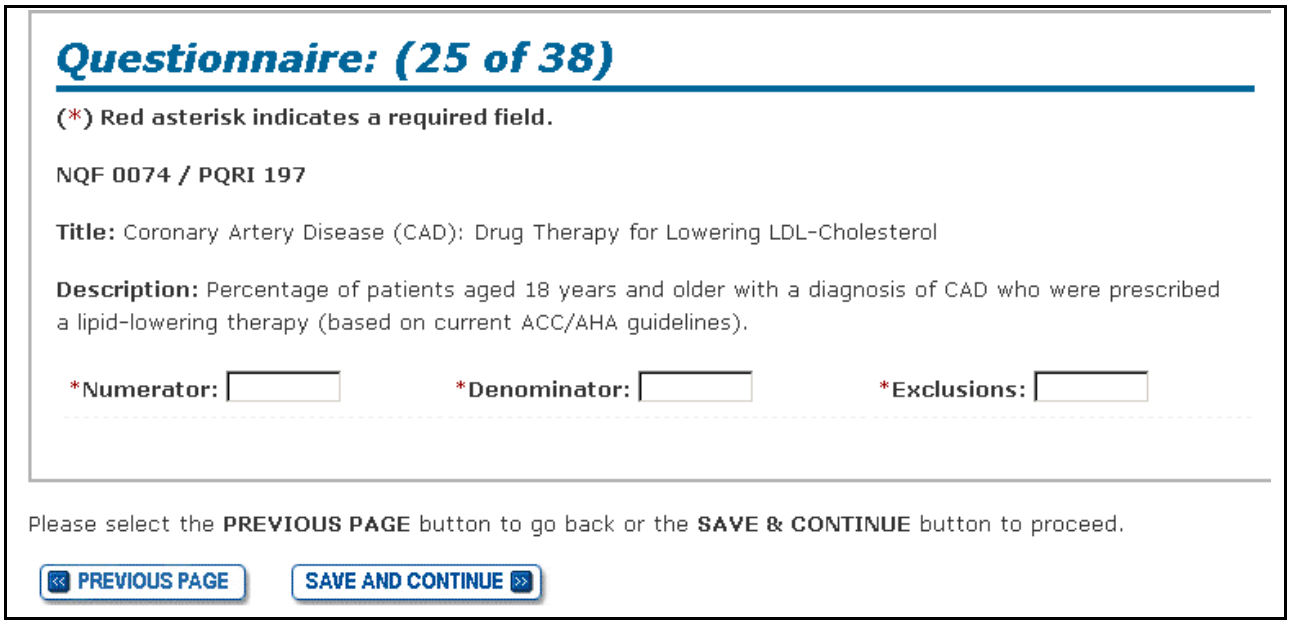
Clinical Quality Measures Question 22 – Diabetes: Eye Exam


Questionnaire: (23 of 38)
(*) Red asterisk indicates a required field.
NQF 0062 / PQRI 119
Title: Diabetes: Urine Screening
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a nephropathy screening test or evidence of nephropathy.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

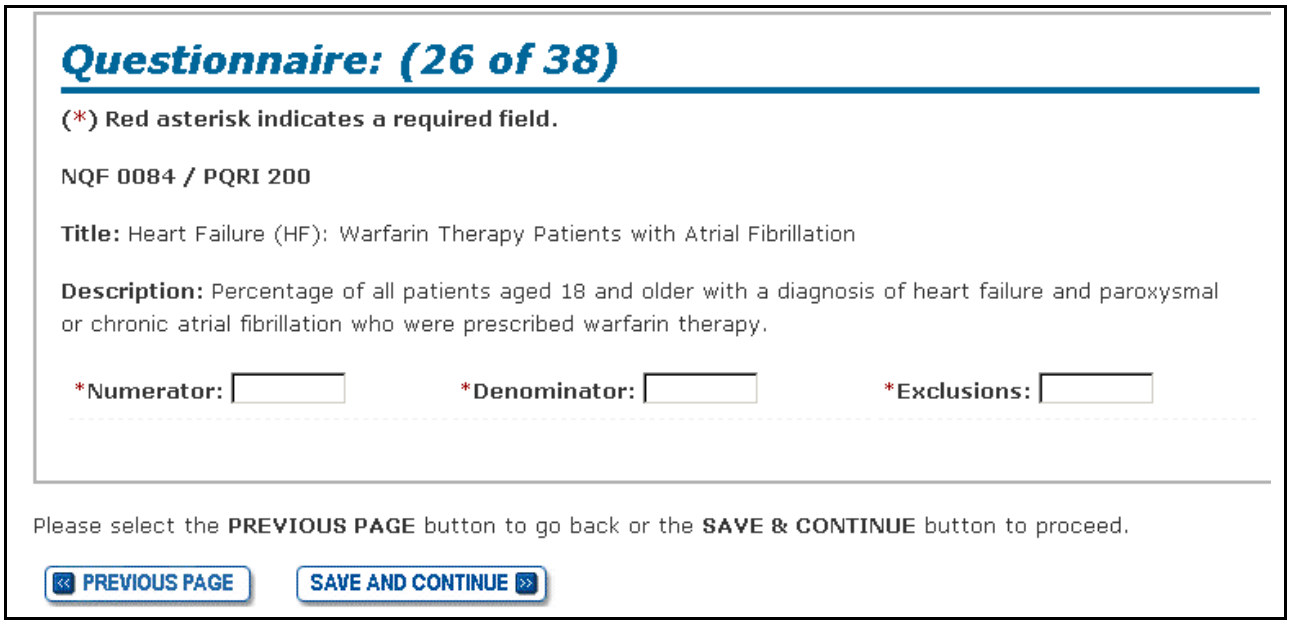
Clinical Quality Measure Question 23 – Diabetes: Urine Screening


Questionnaire: (24 of 38)
(*) Red asterisk indicates a required field.
NQF 0056 / PQRI 163
Title: Diabetes: Foot Exam
Description: The percentage of patients aged 18-75 years with diabetes (type 1 or type 2) who had a foot exam (visual inspection, sensory exam with monofilament, or pulse exam).
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

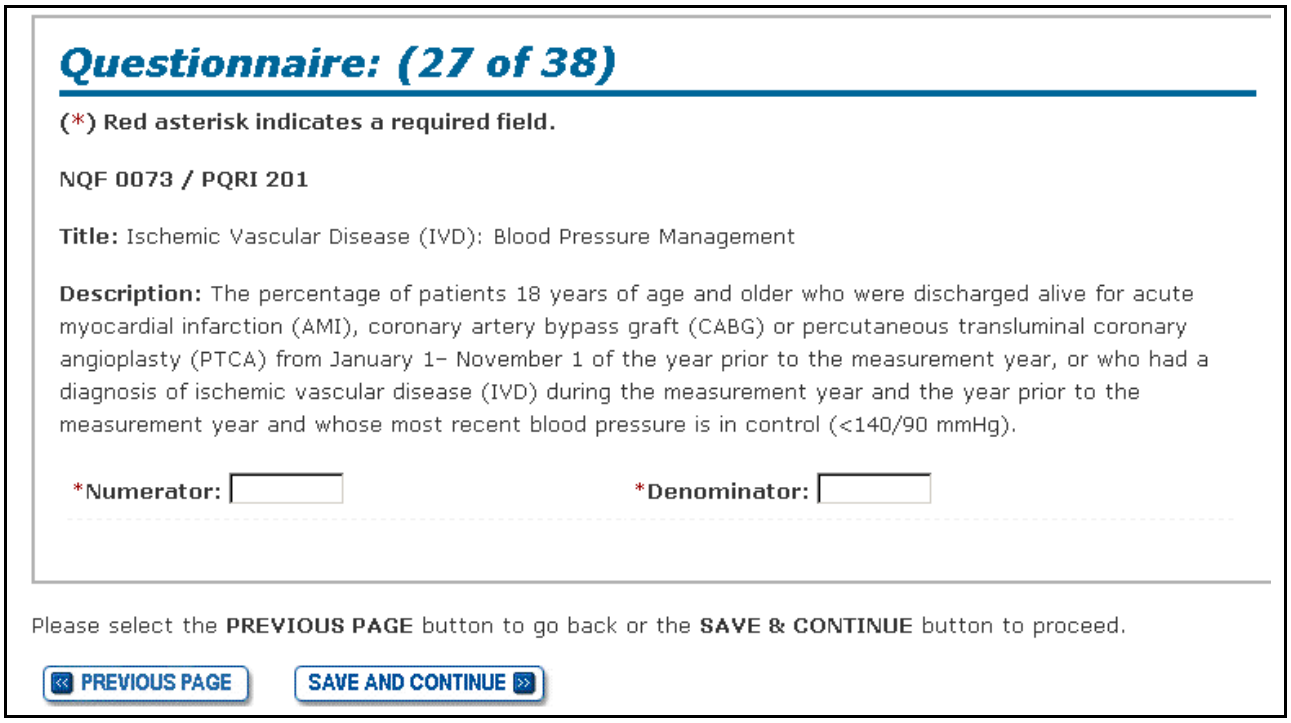
Clinical Quality Measure Question 24 – Diabetes: Foot Exam


Questionnaire: (25 of 38)
(*) Red asterisk indicates a required field.
NQF 0074 / PQRI 197
Title: Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol
Description: Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines).
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

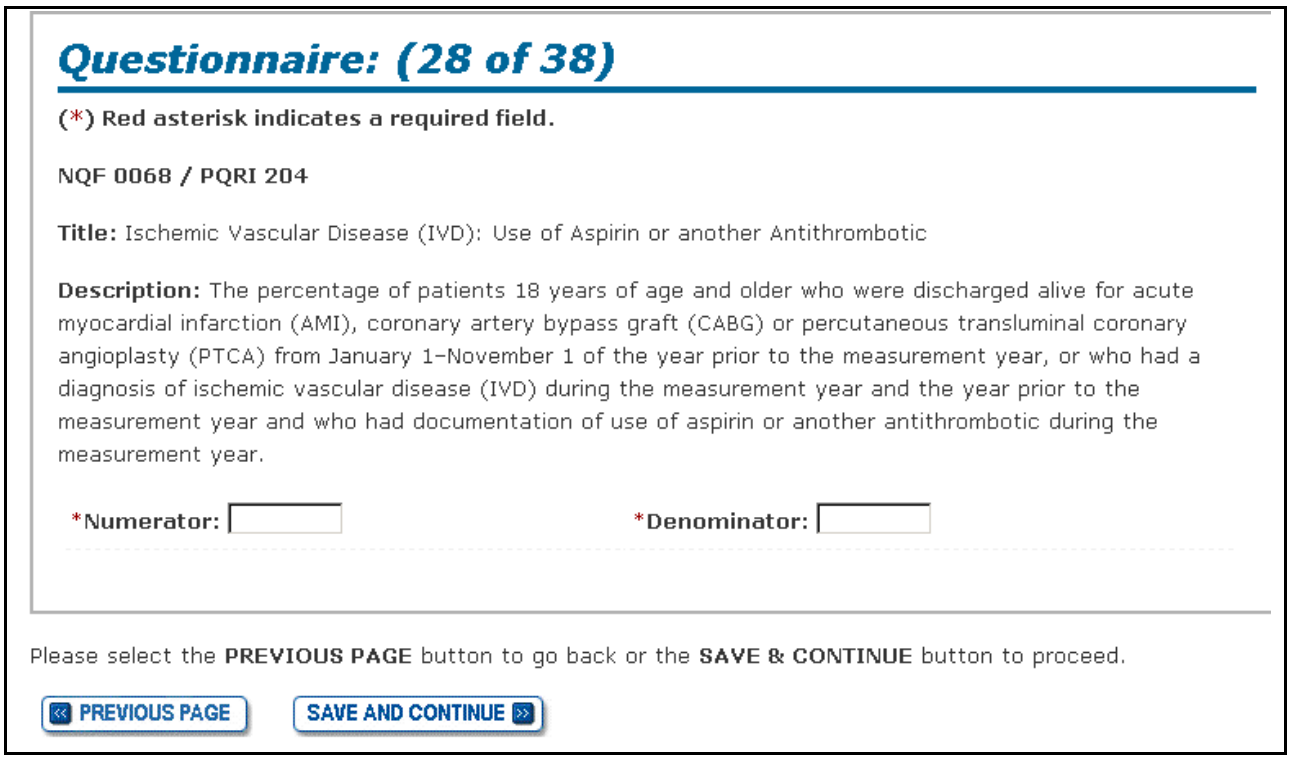
Clinical Quality Measure Question 25 – CAD: Drug Therapy for Lowering LDL-Cholesterol


Questionnaire: (26 of 38)
(*) Red asterisk indicates a required field.
NQF 0084 / PQRI 200
Title: Heart Failure (HF): Warfarin Therapy Patients with Atrial Fibrillation
Description: Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

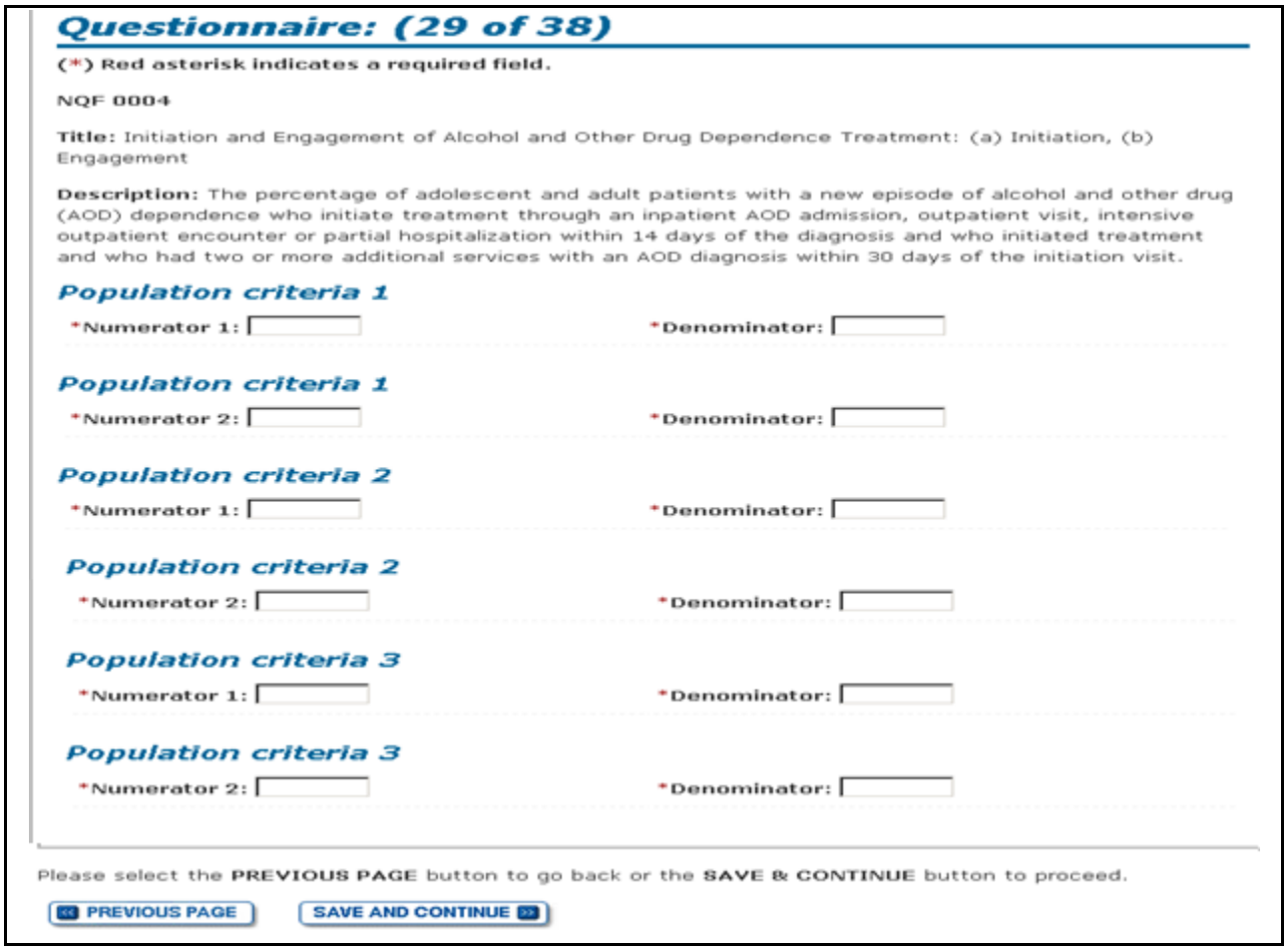
Clinical Quality Measure Question 26 – Heart Failure: Warfarin Therapy Patients with Atrial Fibrillation


Questionnaire: (27 of 38)
(*) Red asterisk indicates a required field.
NQF 0073 / PQRI 201
Title: Ischemic Vascular Disease (IVD): Blood Pressure Management
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and whose most recent blood pressure is in control (<140/90 mmHg).
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

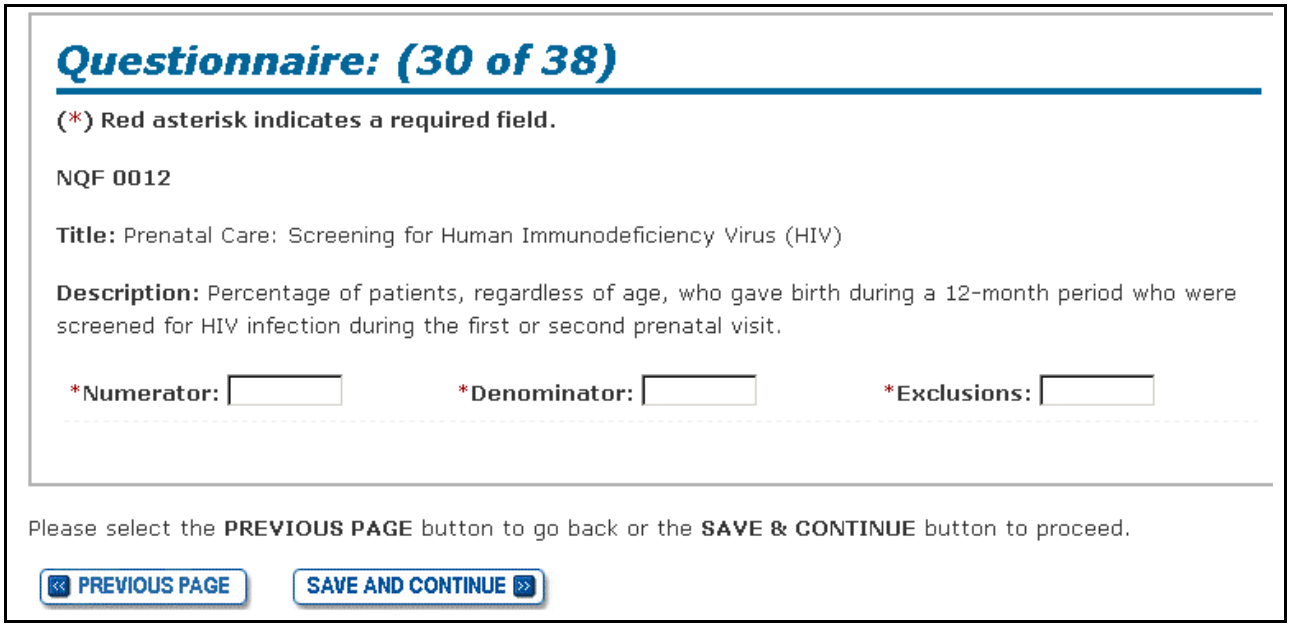
Clinical Quality Measure Question 27 – IVD: Blood Pressure Management


Questionnaire: (28 of 38)
(*) Red asterisk indicates a required field.
NQF 0068 / PQRI 204
Title: Ischemic Vascular Disease (IVD): Use of Aspirin or another Antithrombotic
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1-November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had documentation of use of aspirin or another antithrombotic during the measurement year.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

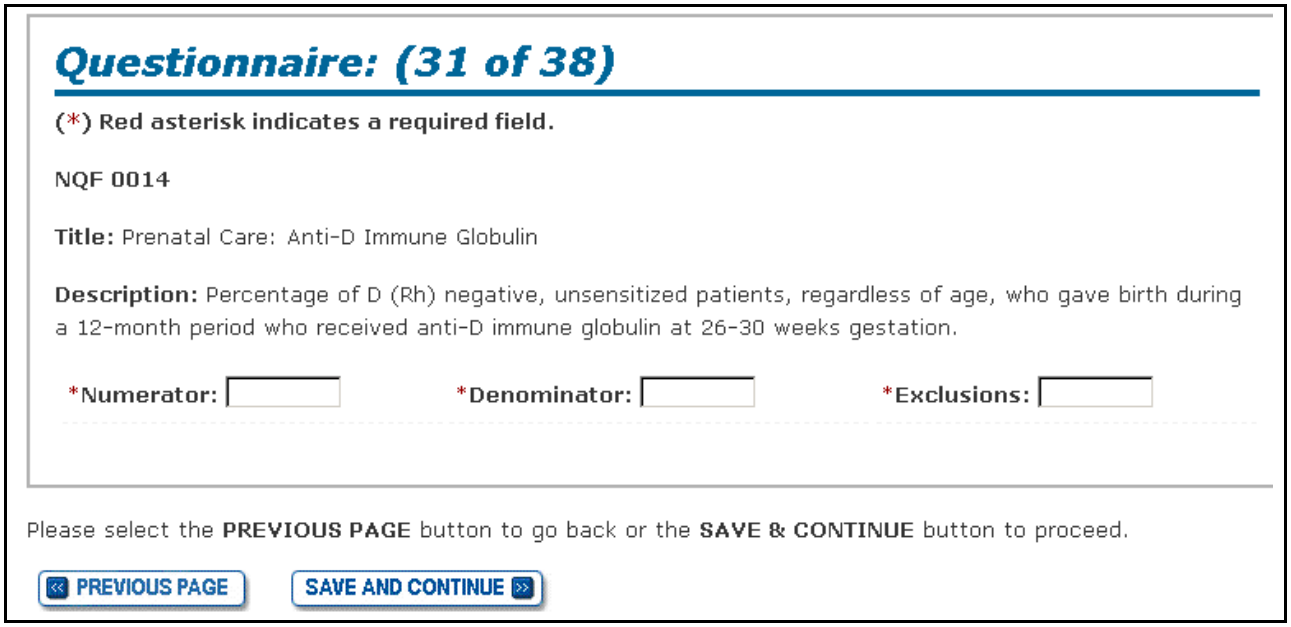
Clinical Quality Measure Question 28 – IVD: Use of Aspirin or another Antithrombotic


Questionnaire: (29 of 38)
(*) Red asterisk indicates a required field.
NQF 0004
Title: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: (a) Initiation, (b) Engagement
Description: The percentage of adolescent and adult patients with a new episode of alcohol and other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis and who initiated treatment and who had two or more additional services with an AOD diagnosis within 30 days of the initiation visit.
Population criteria 1
*Numerator 1:
*Denominator:
Population criteria 1
*Numerator 2:
*Denominator:
Population criteria 2
*Numerator 1:
*Denominator:
Population criteria 2
*Numerator 2:
*Denominator:
Population criteria 3
*Numerator 1:
*Denominator:
Population criteria 3
*Numerator 2:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

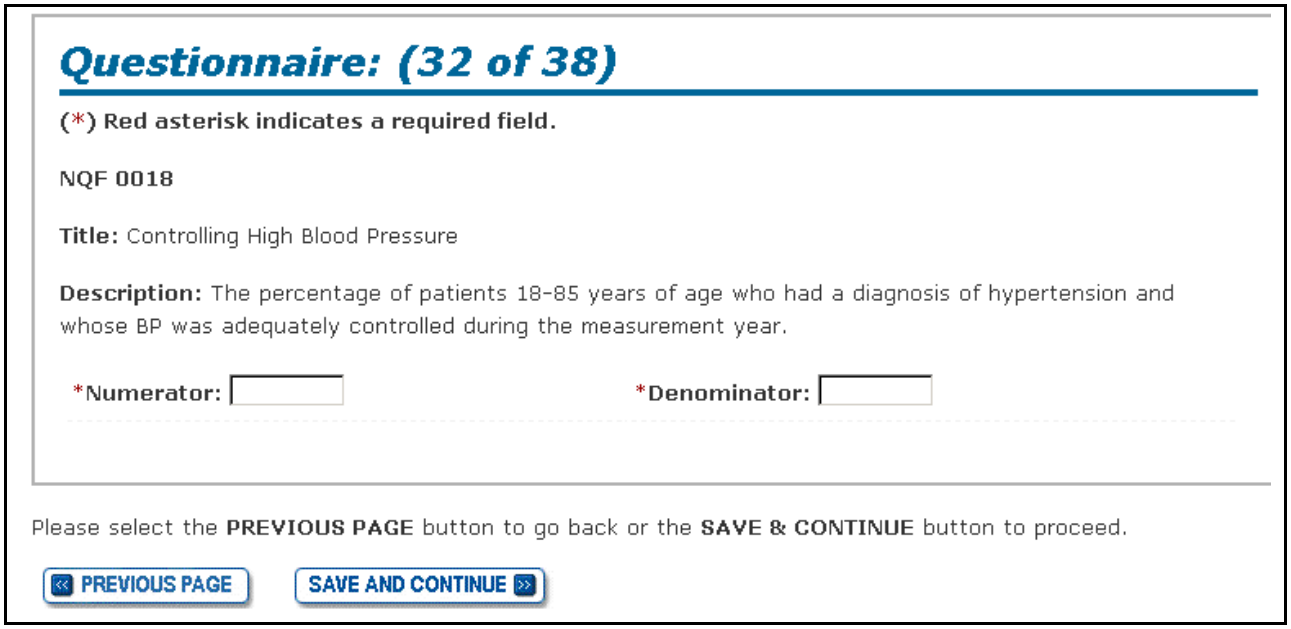
Clinical Quality Measure Question 29 – Initiation and Engagement of Alcohol and Other Drug Dependence Treatment


Questionnaire: (30 of 38)
(*) Red asterisk indicates a required field.
NQF 0012
Title: Prenatal Care: Screening for Human Immunodeficiency Virus (HIV)
Description: Percentage of patients, regardless of age, who gave birth during a 12-month period who were screened for HIV infection during the first or second prenatal visit.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

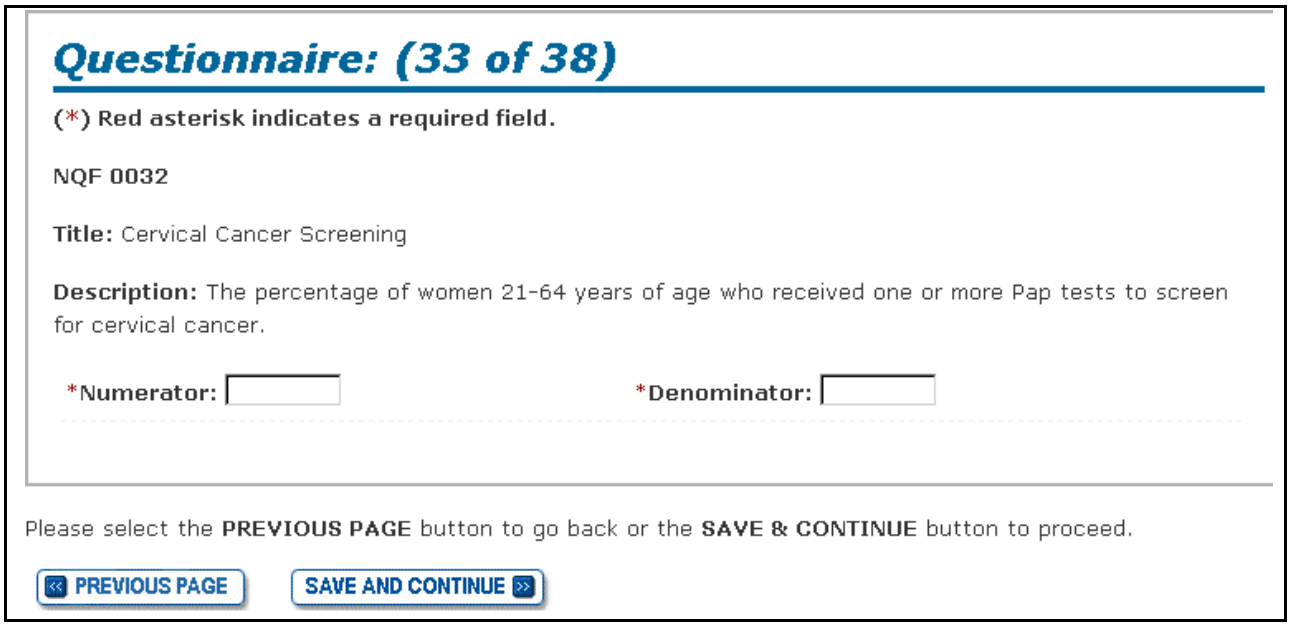
Clinical Quality Measure Question 30 – Prenatal Care: Screening for HIV


Questionnaire: (31 of 38)
(*) Red asterisk indicates a required field.
NQF 0014
Title: Prenatal Care: Anti-D Immune Globulin
Description: Percentage of D (Rh) negative, unsensitized patients, regardless of age, who gave birth during a 12-month period who received anti-D immune globulin at 26-30 weeks gestation.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

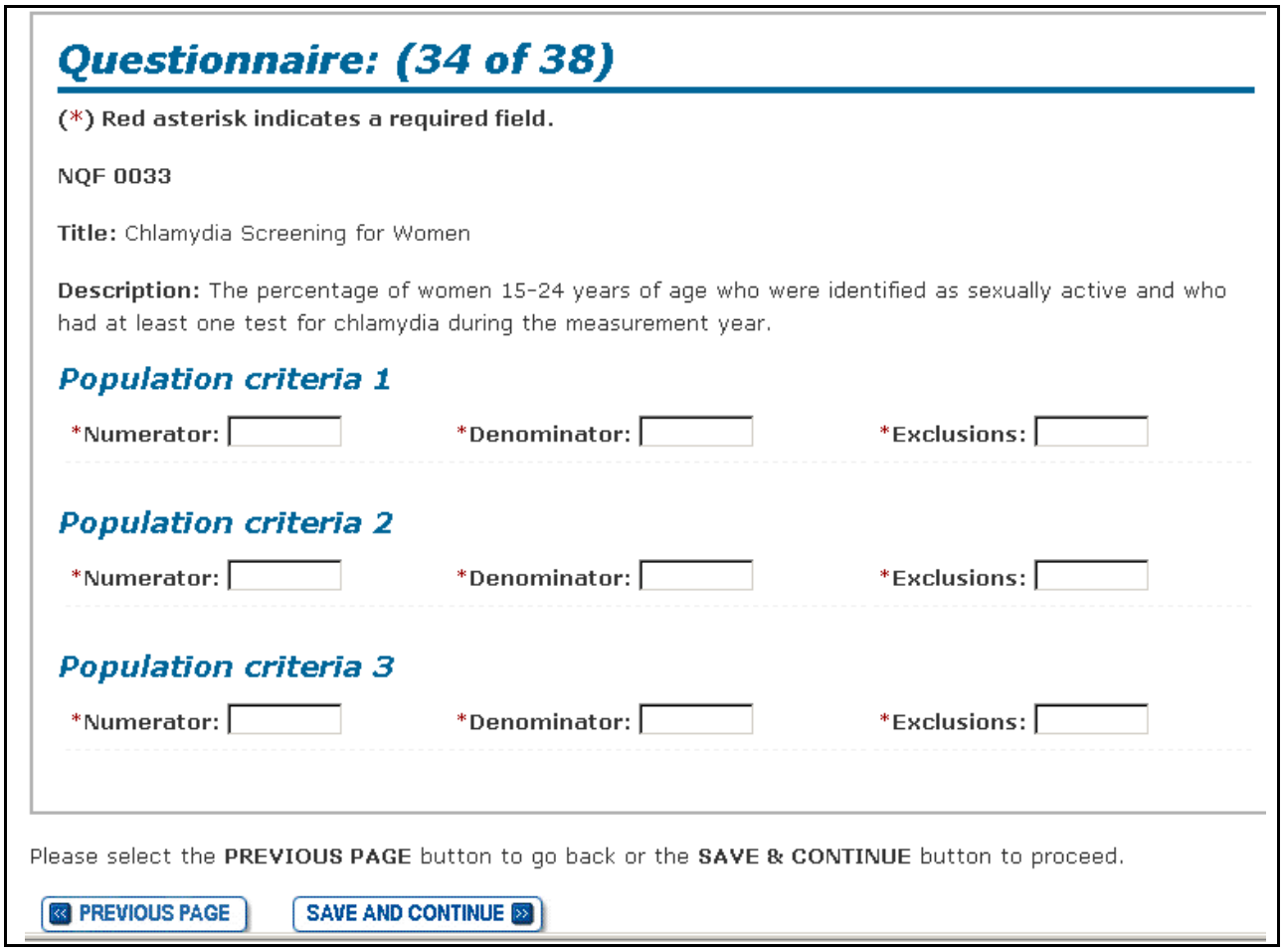
Clinical Quality Measure Question 31 – Prenatal Care: Anti-D Immune Globulin


Questionnaire: (32 of 38)
(*) Red asterisk indicates a required field.
NQF 0018
Title: Controlling High Blood Pressure
Description: The percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose BP was adequately controlled during the measurement year.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

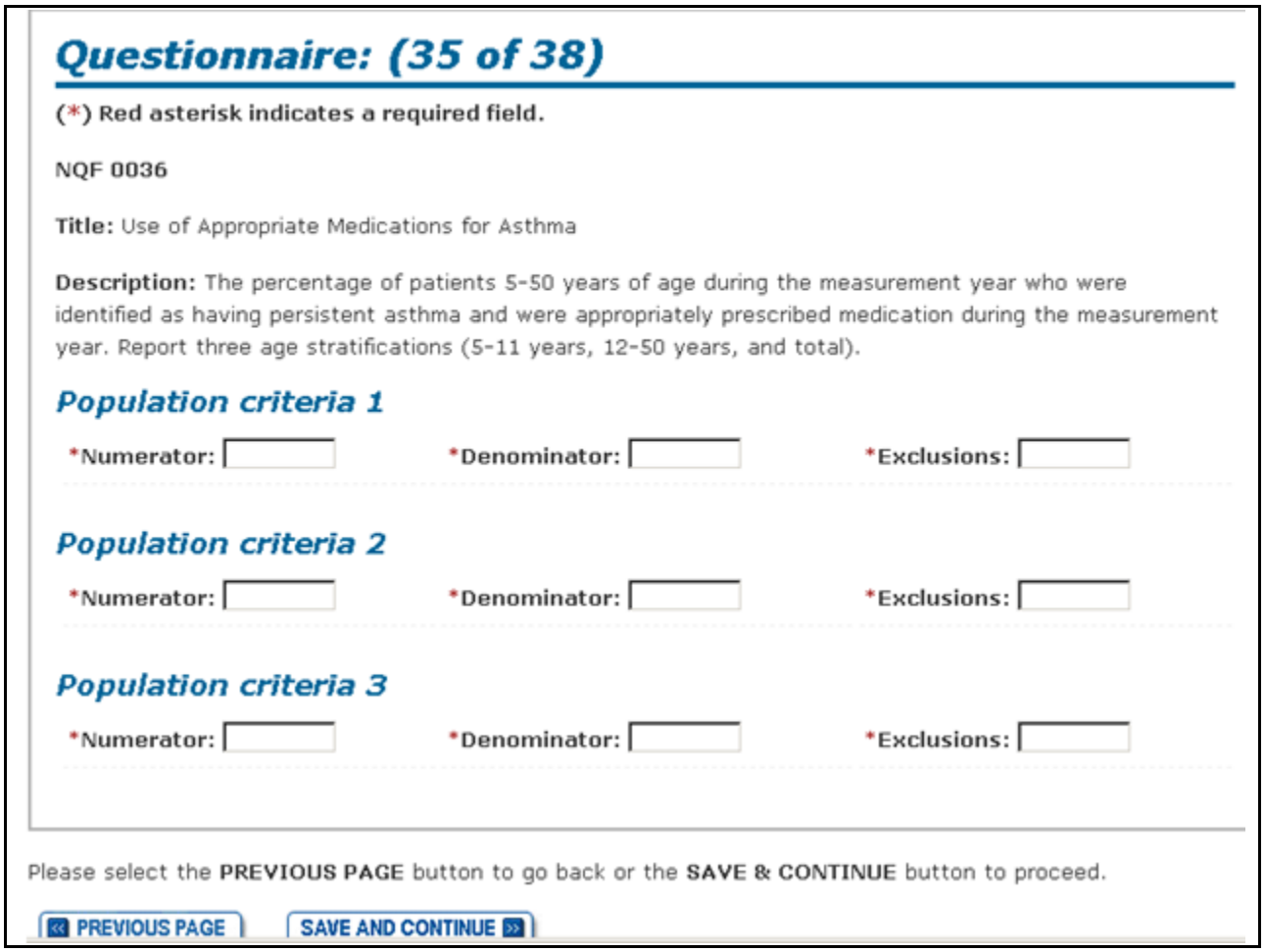
Clinical Quality Measure Question 32 – Controlling High Blood Pressure


Questionnaire: (33 of 38)
(*) Red asterisk indicates a required field.
NQF 0032
Title: Cervical Cancer Screening
Description: The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

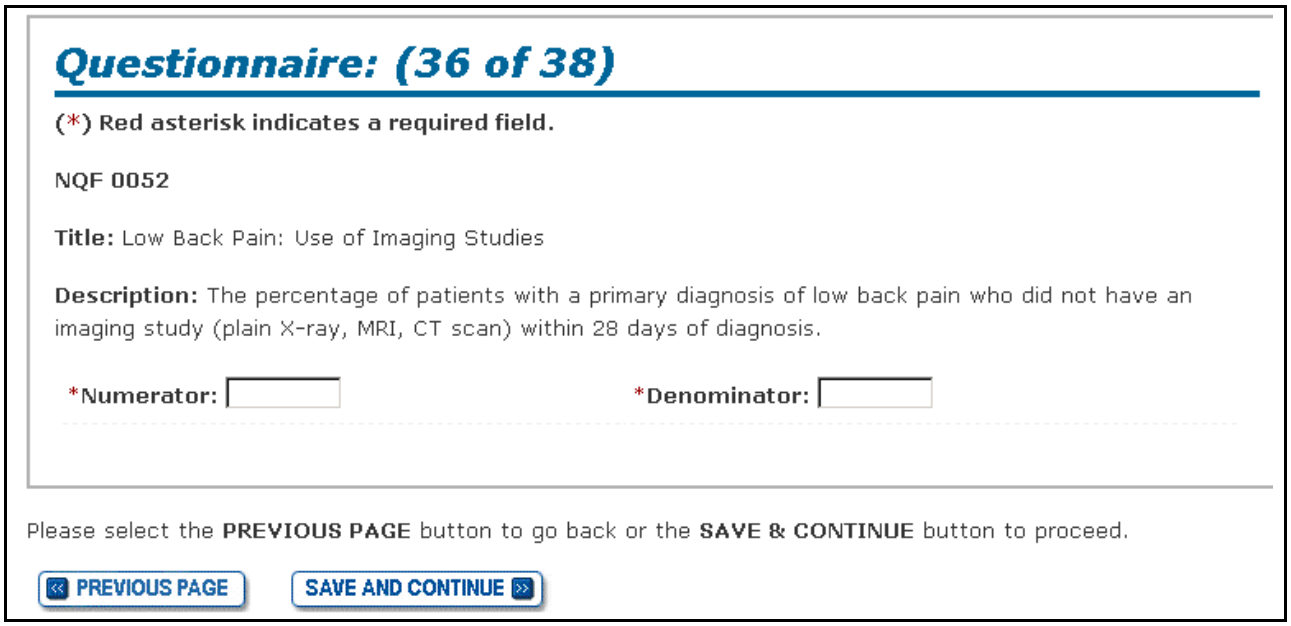
Clinical Quality Measure Question 33 – Cervical Cancer Screening


Questionnaire: (34 of 38)
(*) Red asterisk indicates a required field.
NQF 0033
Title: Chlamydia Screening for Women
Description: The percentage of women 15-24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year.
Population criteria 1
*Numerator:
*Denominator:
*Exclusions:
Population criteria 2
*Numerator:
*Denominator:
*Exclusions:
Population criteria 3
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

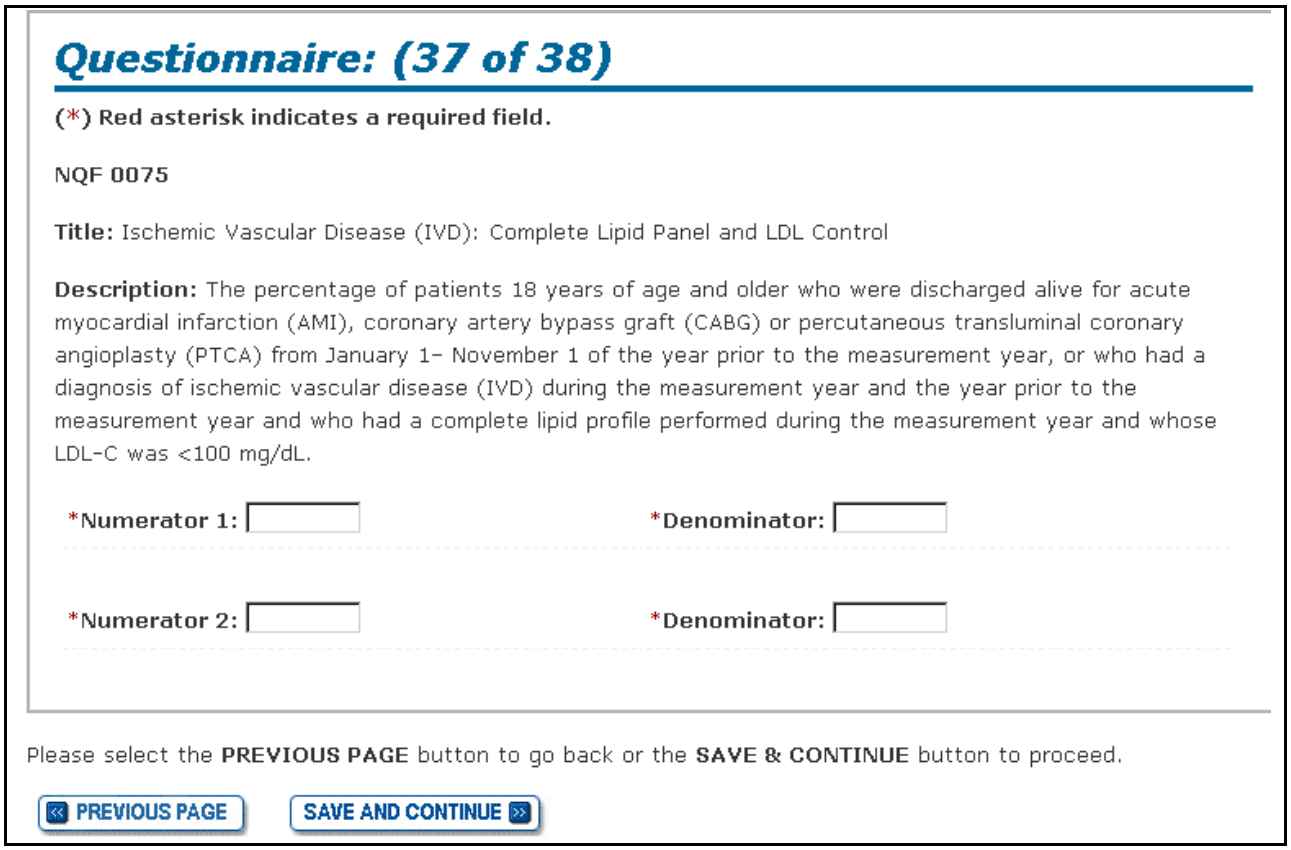
Clinical Quality Measure Question 34 – Chlamydia Screening for Women


Questionnaire: (35 of 38)
(*) Red asterisk indicates a required field.
NQF 0036
Title: Use of Appropriate Medications for Asthma
Description: The percentage of patients 5-50 years of age during the measurement year who were identified as having persistent asthma and were appropriately prescribed medication during the measurement year. Report three age stratifications (5-11 years, 12-50 years, and total).
Population criteria 1
*Numerator:
*Denominator:
*Exclusions:
Population criteria 2
*Numerator:
*Denominator:
*Exclusions:
Population criteria 3
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

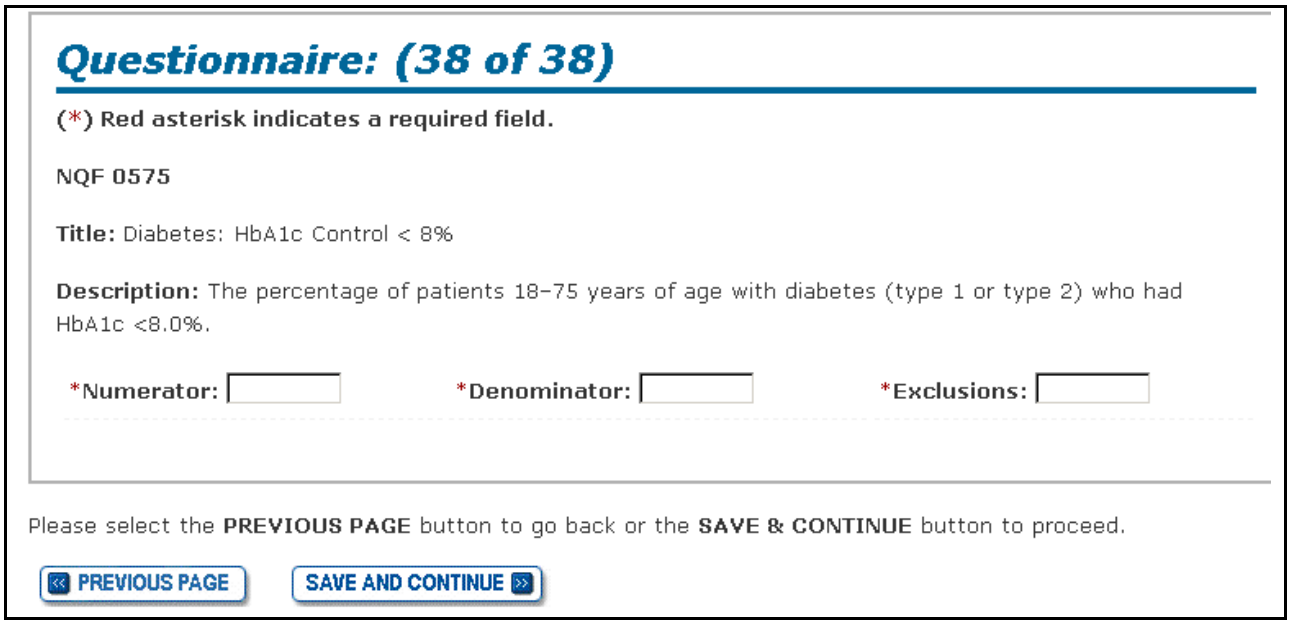
Clinical Quality Measure Question 35 – Use of Appropriate Medications for Asthma


Questionnaire: (36 of 38)
(*) Red asterisk indicates a required field.
NQF 0052
Title: Low Back Pain: Use of Imaging Studies
Description: The percentage of patients with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of diagnosis.
*Numerator:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 36 – Low Back Pain: Use of Imaging Studies


Questionnaire: (37 of 38)
(*) Red asterisk indicates a required field.
NQF 0075
Title: Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control
Description: The percentage of patients 18 years of age and older who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1- November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year and who had a complete lipid profile performed during the measurement year and whose LDL-C was <100 mg/dL.
*Numerator 1:
*Denominator:
*Numerator 2:
*Denominator:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 37 – Ischemic Vascular Disease (IVD): Complete Lipid Panel and LDL Control


Questionnaire: (38 of 38)
(*) Red asterisk indicates a required field.
NQF 0575
Title: Diabetes: HbA1c Control < 8%
Description: The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had HbA1c <8.0%.
*Numerator:
*Denominator:
*Exclusions:
Please select the PREVIOUS PAGE button to go back or the SAVE & CONTINUE button to proceed.
PREVIOUS PAGE
SAVE AND CONTINUE

Clinical Quality Measure Question 38 – Diabetes: HbA1c Control < 8%